

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/19/2019 2:13 pm
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/19/2019	Time: 2:13 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (14-1329) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CAMI MEGLI

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	4,869	-219,182	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	-11,888	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		11,211		0	10.00
200.00 Total	0	-7,019	-207,971	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: 14-1329		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 2:13 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 303 JACKSON			PO Box:				1.00		
2.00	City: MORRISON			State: IL		Zip Code: 61270		County: WHITESIDE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						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.					2	N			23.00
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1329		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 2:13 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	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:	Ending:		
							1.00	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	Y/N		
							1.00	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	XVIII	XIX	
							1.00	2.00	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	45.00
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	46.00
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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
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			56.00
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.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 2:13 pm	
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	N	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.		N	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.		N	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.		N	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.		N	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.		N	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	
			1.00	2.00	
			Speech	Respiratory	
			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	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 2:13 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	335,503	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: 14-1329		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 2:13 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								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: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/19/2019 2:13 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/17/2019	Y
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: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		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.	JILL	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-455-9706	JILL.NELSON@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	3,600.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	3,600.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	3,600.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	71	0	150			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,034	0	2,615			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	572			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,105	0	3,337			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)	2,105	0	3,337	0.00	115.47	14.00
15.00	CAH visits	2,480	214	6,966			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	3,866	1,041	21,518	0.00	21.62	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	137.09	27.00
28.00	Observation Bed Days		1	90			28.00
29.00	Ambulance Trips	236					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: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	28	0	51	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	28	0	51	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1329 Component CCN: 14-3981		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/19/2019 2:13 pm		
				RHC I		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				300 NORTH JACKSON STREET			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				MORRISON IL 61270			2.00		
						1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)							4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00		
7.00	Appalachian Regional Commission							7.00		
8.00	Look-Alikes							8.00		
9.00	OTHER (SPECIFY)							9.00		
						1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from to		from to		from		
				1.00 2.00		3.00 4.00		5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:00	18:00	08:00	18:00	08:00	11.00
						1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		XVIII		
				1.00		2.00		3.00		
								XIX		
								Total Visits		
								5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				WHITESIDE				2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
Facility hours of operations (1)										
11.00	CLINIC				18:00	08:00	18:00	08:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1329 Component CCN: 14-3981		Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/19/2019 2:13 pm
					RHC I	Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	18:00	08:00	18:00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1329

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

Worksheet S-10

Date/Time Prepared:
11/19/2019 2:13 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.608199	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		190,537	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		669,078	6.00
7.00	Medicaid cost (line 1 times line 6)		406,933	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)		216,396	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)		216,396	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,247	24,860	29,107
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,583	24,860	27,443
22.00	Payments received from patients for amounts previously written off as charity care	1,687	9,752	11,439
23.00	Cost of charity care (line 21 minus line 22)	896	15,108	16,004
			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)		2,108,699	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		34,502	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		53,080	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,055,619	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,268,803	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,284,807	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,501,203	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1329

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

Worksheet A

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		472,779	472,779	-32,836	439,943	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		153,330	153,330	158,782	312,112	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,303,490	2,303,490	-240,824	2,062,666	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	53,727	-4,579	49,148	0	49,148	5.01
5.02	00591	PERSONNEL	74,500	8,346	82,846	0	82,846	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	334,867	99,615	434,482	0	434,482	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	489,841	435,003	924,844	263,510	1,188,354	5.05
7.00	00700	OPERATION OF PLANT	180,210	326,037	506,247	0	506,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,257	29,257	0	29,257	8.00
9.00	00900	HOUSEKEEPING	174,289	20,602	194,891	0	194,891	9.00
10.00	01000	DIETARY	213,651	95,159	308,810	0	308,810	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	113,875	46,509	160,384	0	160,384	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,784	46,056	69,840	0	69,840	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	261,893	54,053	315,946	0	315,946	16.00
17.00	01700	SOCIAL SERVICE	71,617	488	72,105	0	72,105	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,505,343	175,972	1,681,315	-518	1,680,797	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	376,480	218,004	594,484	11,604	606,088	50.00
53.00	05300	ANESTHESIOLOGY	0	317,511	317,511	-1,399	316,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,645	194,126	598,771	273	599,044	54.00
60.00	06000	LABORATORY	462,954	386,284	849,238	2,537	851,775	60.00
64.00	06400	INTRAVENOUS THERAPY	0	47,199	47,199	24,612	71,811	64.00
65.00	06500	RESPIRATORY THERAPY	0	53,368	53,368	-50,476	2,892	65.00
66.00	06600	PHYSICAL THERAPY	278,653	8,452	287,105	0	287,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,923	1,610	212,533	0	212,533	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,500	14,500	0	14,500	68.00
69.00	06900	ELECTROCARDIOLOGY	4,126	12,445	16,571	0	16,571	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,979	45,979	51,537	97,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	572,994	572,994	0	572,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,151	364,274	517,425	0	517,425	73.00
76.00	03950	NEUROLOGY	0	19,238	19,238	0	19,238	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,660,319	639,825	3,300,144	203,894	3,504,038	88.00
91.00	09100	EMERGENCY	365,107	1,652,766	2,017,873	-281,309	1,736,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	59,043	6,085	65,128	0	65,128	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	104,752	32,927	137,679	-5,961	131,718	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		103,426	103,426	-103,426	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,577,750	8,953,130	17,530,880	0	17,530,880	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	8,577,750	8,953,130	17,530,880	0	17,530,880	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet A
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	439,943	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-36,551	275,561	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,564	2,056,102	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	49,148	5.01
5.02	00591	PERSONNEL	0	82,846	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-20,367	414,115	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-22,228	1,166,126	5.05
7.00	00700	OPERATION OF PLANT	0	506,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,257	8.00
9.00	00900	HOUSEKEEPING	0	194,891	9.00
10.00	01000	DIETARY	-78,290	230,520	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	160,384	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	69,840	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,378	311,568	16.00
17.00	01700	SOCIAL SERVICE	0	72,105	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,680,797	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-150,950	455,138	50.00
53.00	05300	ANESTHESIOLOGY	-203,131	112,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-19,253	579,791	54.00
60.00	06000	LABORATORY	-23,502	828,273	60.00
64.00	06400	INTRAVENOUS THERAPY	-285	71,526	64.00
65.00	06500	RESPIRATORY THERAPY	-5	2,887	65.00
66.00	06600	PHYSICAL THERAPY	-15,392	271,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	212,533	67.00
68.00	06800	SPEECH PATHOLOGY	-2,155	12,345	68.00
69.00	06900	ELECTROCARDIOLOGY	-8,874	7,697	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-413	97,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-3,396	569,598	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,796	511,629	73.00
76.00	03950	NEUROLOGY	0	19,238	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-85,924	3,418,114	88.00
91.00	09100	EMERGENCY	-218,394	1,518,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	-268	64,860	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	131,718	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-906,116	16,624,764	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-906,116	16,624,764	200.00

RECLASSIFICATIONS

Provider CCN: 14-1329

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

Worksheet A-6

Date/Time Prepared:
11/19/2019 2:13 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	89,547	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.05	0	7,229	2.00	
3.00	OPERATING ROOM	50.00	0	3,840	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	273	4.00	
5.00	LABORATORY	60.00	0	2,537	5.00	
	TOTALS		0	103,426		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,022	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,377	2.00	
3.00	ADMINISTRATIVE & GENERAL	5.05	0	256,281	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	292,680		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	151,405	1.00	
	TOTALS		0	151,405		
	D - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	51,537	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		0	51,537		
	E - RHC PHYSICIAN IN ER					
1.00	RURAL HEALTH CLINIC	88.00	0	24,900	1.00	
2.00	EMERGENCY	91.00	0	912	2.00	
	TOTALS		0	25,812		
	F - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	24,612	0	1.00	
	TOTALS		24,612	0		
	G - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	232,148	1.00	
2.00	OPERATING ROOM	50.00	0	8,676	2.00	
	TOTALS		0	240,824		
500.00	Grand Total: Increases		24,612	865,684	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1329

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

Worksheet A-6

Date/Time Prepared:
11/19/2019 2:13 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	103,426	11	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		0	103,426		
B - INSURANCE						
1.00	ANESTHESIOLOGY	53.00	0	1,399	12	1.00
2.00	EMERGENCY	91.00	0	257,066	12	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	28,254	0	3.00
4.00	AMBULANCE SERVICES	95.00	0	5,961	0	4.00
	TOTALS		0	292,680		
C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	151,405	9	1.00
	TOTALS		0	151,405		
D - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	518	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	50,476	0	2.00
3.00	EMERGENCY	91.00	0	543	0	3.00
	TOTALS		0	51,537		
E - RHC PHYSICIAN IN ER						
1.00	RURAL HEALTH CLINIC	88.00	0	24,900	0	1.00
2.00	OPERATING ROOM	50.00	0	912	0	2.00
	TOTALS		0	25,812		
F - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	24,612	0	0	1.00
	TOTALS		24,612	0		
G - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	240,824	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	240,824		
500.00	Grand Total: Decreases		24,612	865,684		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	21,657	192,505	0	192,505	0	1.00	
2.00	Land Improvements	431,331	-1,407	0	-1,407	0	2.00	
3.00	Buildings and Fixtures	9,860,272	2,476,184	0	2,476,184	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	824,347	115,132	0	115,132	0	5.00	
6.00	Movable Equipment	4,970,233	113,112	0	113,112	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	16,107,840	2,895,526	0	2,895,526	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	16,107,840	2,895,526	0	2,895,526	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	214,162	0					1.00
2.00	Land Improvements	429,924	0					2.00
3.00	Buildings and Fixtures	12,336,456	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	939,479	0					5.00
6.00	Movable Equipment	5,083,345	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	19,003,366	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	19,003,366	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	472,779	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	153,330	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	626,109	0	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	472,779				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	153,330				2.00
3.00	Total (sum of lines 1-2)	0	626,109				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,920,021	0	13,920,021	0.732503	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,083,345	0	5,083,345	0.267497	0	2.00
3.00	Total (sum of lines 1-2)	19,003,366	0	19,003,366	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	321,374	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	268,184	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	589,558	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	89,547	29,022	0	0	439,943	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,377	0	0	275,561	2.00
3.00	Total (sum of lines 1-2)	89,547	36,399	0	0	715,504	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1329

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

Worksheet A-8

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,365	ADMINISTRATIVE & GENERAL	5.05	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	-624,979			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	B	-63,871	DIETARY	10.00	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	-4,378	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-36,551	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CATERING REVENUE	B	-14,419	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1329

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

Worksheet A-8

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00		
33.01 LAB OTHER REVENUE	B	-12,158	LABORATORY	60.00	0	33.01
33.02 REHAB MISC REV	B	-9,370	PHYSICAL THERAPY	66.00	0	33.02
33.03 OTHER REV -A&G	B	-146	ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04 NONALLOWABLE DUES	B	-5,798	ADMINISTRATIVE & GENERAL	5.05	0	33.04
33.05 PATIENT TELEPHONE - SALARIES	A	-5,442	ADMINISTRATIVE & GENERAL	5.05	0	33.05
33.06 PATIENT TELEPHONE - BENEFITS	A	-1,095	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07 PHYSICIAN BILLING SALARIES	A	-20,367	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.07
33.08 PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-5,469	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09 PHARMACY DRUG RETAIL 340B	A	-4,509	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.10 ADVERTISING	A	-9,447	ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11 OTHER REV- EDUCATION	A	-30	ADMINISTRATIVE & GENERAL	5.05	0	33.11
33.12 SELF INSURANCE EXPENSE	A	-9,198	OPERATING ROOM	50.00	0	33.12
33.13 SELF INSURANCE EXPENSE	A	-1,481	ANESTHESIOLOGY	53.00	0	33.13
33.14 SELF INSURANCE EXPENSE	A	-11,753	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15 SELF INSURANCE EXPENSE	A	-11,344	LABORATORY	60.00	0	33.15
33.16 SELF INSURANCE EXPENSE	A	-285	INTRAVENOUS THERAPY	64.00	0	33.16
33.17 SELF INSURANCE EXPENSE	A	-5	RESPIRATORY THERAPY	65.00	0	33.17
33.18 SELF INSURANCE EXPENSE	A	-6,022	PHYSICAL THERAPY	66.00	0	33.18
33.19 SELF INSURANCE EXPENSE	A	-2,155	SPEECH PATHOLOGY	68.00	0	33.19
33.20 SELF INSURANCE EXPENSE	A	-166	ELECTROCARDIOLOGY	69.00	0	33.20
33.21 SELF INSURANCE EXPENSE	A	-413	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.21
33.22 SELF INSURANCE EXPENSE	A	-3,396	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33.22
33.23 SELF INSURANCE EXPENSE	A	-1,287	DRUGS CHARGED TO PATIENTS	73.00	0	33.23
33.24 SELF INSURANCE EXPENSE	A	-268	WOUND CARE	93.00	0	33.24
33.25 SELF INSURANCE EXPENSE	A	-9,144	EMERGENCY	91.00	0	33.25
33.26 SELF INSURANCE EXPENSE	A	-29,805	RURAL HEALTH CLINIC	88.00	0	33.26
33.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
33.30 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-906,116				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: 14-1329

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

Worksheet A-8-2

Date/Time Prepared:
11/19/2019 2:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,342,929	209,250	1,133,679	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	28,350	0	28,350	0	0	2.00
3.00	60.00	LABORATORY	15,000	0	15,000	0	0	3.00
4.00	91.00	EMERGENCY	9,450	0	9,450	0	0	4.00
5.00	50.00	OPERATING ROOM	13,561	13,561	0	0	0	5.00
6.00	50.00	OPERATING ROOM	108,953	108,953	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	7,500	7,500	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	8,708	8,708	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	56,119	56,119	0	0	0	9.00
10.00	50.00	OPERATING ROOM	19,238	19,238	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	201,650	201,650	0	0	0	11.00
200.00			1,811,458	624,979	1,186,479		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	11.00
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	91.00	EMERGENCY	0	0	0	209,250		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	13,561		5.00
6.00	50.00	OPERATING ROOM	0	0	0	108,953		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,500		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,708		8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	56,119		9.00
10.00	50.00	OPERATING ROOM	0	0	0	19,238		10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	201,650		11.00
200.00			0	0	0	624,979		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1329		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2019 2:13 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					39	1.00
2.00	Line 1 multiplied by 15 hours per week					585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					73	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	98.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	95.17	76.14	57.10	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.07	38.07	28.55			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,462	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,462	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,462	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					44,542	22.00
23.00	Total salary equivalency (see instructions)					44,542	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,779	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,779	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					405	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,184	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,184	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1329		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2019 2:13 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	57.10	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						44,542	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,184	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						47,726	63.00
64.00	Total cost of outside supplier services (from your records)						7,875	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,779	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						405	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,184	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						405	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						405	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	439,943	439,943			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	275,561		275,561		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,056,102	0	0	2,056,102	4.00
5.01	00500	PURCHASING RECEIVING AND STORES	49,148	13,090	0	17,081	79,319 5.01
5.02	00591	PERSONNEL	82,846	2,677	0	23,686	115 5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	414,115	7,914	0	99,988	998 5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,166,126	23,766	11,787	154,004	5,180 5.05
7.00	00700	OPERATION OF PLANT	506,247	80,924	1,726	57,294	921 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,257	10,305	0	0	0 8.00
9.00	00900	HOUSEKEEPING	194,891	4,301	0	55,411	384 9.00
10.00	01000	DIETARY	230,520	11,914	46	67,926	422 10.00
11.00	01100	CAFETERIA	0	4,588	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	160,384	4,758	0	36,204	153 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,840	4,023	0	7,562	19,342 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	311,568	10,243	565	83,263	806 16.00
17.00	01700	SOCIAL SERVICE	72,105	1,184	0	22,769	38 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,680,797	72,282	31,298	478,591	3,799 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	455,138	18,181	81,960	85,054	13,661 50.00
53.00	05300	ANESTHESIOLOGY	112,981	0	0	0	1,497 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,791	12,448	118,878	128,648	3,108 54.00
60.00	06000	LABORATORY	828,273	11,783	15,572	147,186	1,765 60.00
64.00	06400	INTRAVENOUS THERAPY	71,526	0	0	7,825	0 64.00
65.00	06500	RESPIRATORY THERAPY	2,887	0	712	0	0 65.00
66.00	06600	PHYSICAL THERAPY	271,713	20,192	0	88,592	2,111 66.00
67.00	06700	OCCUPATIONAL THERAPY	212,533	3,830	0	67,058	0 67.00
68.00	06800	SPEECH PATHOLOGY	12,345	944	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	7,697	0	1,644	1,312	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	97,103	0	0	0	460 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	569,598	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	511,629	3,744	3,627	48,691	1,266 73.00
76.00	03950	NEUROLOGY	19,238	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,418,114	81,543	5,402	217,629	9,632 88.00
91.00	09100	EMERGENCY	1,518,170	10,212	2,344	108,253	10,246 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	WOUND CARE	64,860	2,375	0	18,771	38 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	131,718	21,817	0	33,304	3,377 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,624,764	439,038	275,561	2,056,102	79,319 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0 194.00
194.01	07951	RENTAL SPACE	0	905	0	0	0 194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	16,624,764	439,943	275,561	2,056,102	79,319 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			PERSONNEL	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	109,324					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	4,333	527,348				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	6,338	0	1,367,201	1,367,201		5.05
7.00	00700	OPERATION OF PLANT	2,332	0	649,444	58,195	707,639	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	39,562	3,545	23,405	8.00
9.00	00900	HOUSEKEEPING	2,255	0	257,242	23,051	9,770	9.00
10.00	01000	DIETARY	2,764	0	313,592	28,100	27,059	10.00
11.00	01100	CAFETERIA	0	0	4,588	411	10,420	11.00
13.00	01300	NURSING ADMINISTRATION	1,473	0	202,972	18,188	10,806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	308	0	101,075	9,057	9,137	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,388	0	409,833	36,724	23,264	16.00
17.00	01700	SOCIAL SERVICE	927	0	97,023	8,694	2,688	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,476	34,740	2,320,983	207,979	164,166	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,871	93,306	752,171	67,401	41,292	50.00
53.00	05300	ANESTHESIOLOGY	0	7,465	121,943	10,927	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,235	70,829	918,937	82,344	28,272	54.00
60.00	06000	LABORATORY	5,990	58,720	1,069,289	95,817	26,761	60.00
64.00	06400	INTRAVENOUS THERAPY	318	17,613	97,282	8,717	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,481	8,080	724	0	65.00
66.00	06600	PHYSICAL THERAPY	3,605	23,496	409,709	36,713	45,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,729	13,254	299,404	26,829	8,698	67.00
68.00	06800	SPEECH PATHOLOGY	0	438	13,727	1,230	2,144	68.00
69.00	06900	ELECTROCARDIOLOGY	53	2,606	13,312	1,193	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,514	105,077	9,416	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,832	592,430	53,086	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,981	52,179	623,117	55,836	8,504	73.00
76.00	03950	NEUROLOGY	0	669	19,907	1,784	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34,424	73,302	3,840,046	344,102	185,199	88.00
91.00	09100	EMERGENCY	4,405	29,747	1,683,377	150,844	23,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	764	2,326	89,134	7,987	5,394	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,355	11,831	203,402	18,226	49,550	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,324	527,348	16,623,859	1,367,120	705,583	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	905	81	2,056	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,324	527,348	16,624,764	1,367,201	707,639	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,512					8.00
9.00	00900	HOUSEKEEPING	0	290,063				9.00
10.00	01000	DIETARY	0	1,620	370,371			10.00
11.00	01100	CAFETERIA	0	0	218,380	233,799		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,838	0	3,269	237,073	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,137	0	1,881	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,491	0	17,637	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,512	0	2,352	4,652	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,756	90,711	149,199	68,197	134,906	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,034	16,182	0	10,465	20,709	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,890	14,325	0	16,791	0	54.00
60.00	06000	LABORATORY	0	15,046	0	19,025	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	329	666	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,617	25,804	0	8,701	17,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,890	0	5,056	9,992	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,205	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	282	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	4,011	0	4,515	8,925	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,960	85,455	0	50,842	0	88.00
91.00	09100	EMERGENCY	14,070	13,050	0	18,037	35,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	1,630	0	2,187	4,314	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	185	0	0	4,233	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,512	288,907	367,579	233,799	237,073	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,156	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	2,792	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,512	290,063	370,371	233,799	237,073	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	126,287					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	493,949				16.00
17.00	01700	SOCIAL SERVICE	0	0	116,921			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	30,561	116,921	3,315,379	-30,590	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,742	95,736	0	1,101,732	0	50.00
53.00	05300	ANESTHESIOLOGY	0	11,811	0	144,681	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,550	0	1,127,109	0	54.00
60.00	06000	LABORATORY	0	51,657	0	1,277,595	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	15,494	0	122,488	30,590	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,942	0	12,746	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,670	0	567,290	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,660	0	366,529	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	386	0	18,692	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,957	0	17,744	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,610	0	121,103	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,086	0	665,602	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,903	0	750,811	0	73.00
76.00	03950	NEUROLOGY	0	906	0	22,597	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36,626	64,486	0	4,611,716	0	88.00
91.00	09100	EMERGENCY	919	36,080	0	1,975,264	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	2,046	0	112,692	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	10,408	0	286,004	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,287	493,949	116,921	16,617,774	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	4,198	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	2,792	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	126,287	493,949	116,921	16,624,764	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	5.01
5.02	00591	PERSONNEL	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	NEUROLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	WOUND CARE	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
194.00	07950	OPHTH CLINIC	194.00
194.01	07951	RENTAL SPACE	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	13,090	0	13,090	5.01
5.02	00591	PERSONNEL	0	2,677	0	2,677	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,914	0	7,914	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	23,766	11,787	35,553	5.05
7.00	00700	OPERATION OF PLANT	0	80,924	1,726	82,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,305	0	10,305	8.00
9.00	00900	HOUSEKEEPING	0	4,301	0	4,301	9.00
10.00	01000	DIETARY	0	11,914	46	11,960	10.00
11.00	01100	CAFETERIA	0	4,588	0	4,588	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,758	0	4,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,023	0	4,023	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,243	565	10,808	16.00
17.00	01700	SOCIAL SERVICE	0	1,184	0	1,184	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	72,282	31,298	103,580	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	18,181	81,960	100,141	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,448	118,878	131,326	54.00
60.00	06000	LABORATORY	0	11,783	15,572	27,355	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	712	712	65.00
66.00	06600	PHYSICAL THERAPY	0	20,192	0	20,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,830	0	3,830	67.00
68.00	06800	SPEECH PATHOLOGY	0	944	0	944	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,644	1,644	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,744	3,627	7,371	73.00
76.00	03950	NEUROLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	81,543	5,402	86,945	88.00
91.00	09100	EMERGENCY	0	10,212	2,344	12,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00	04950	WOUND CARE	0	2,375	0	2,375	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	21,817	0	21,817	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	439,038	275,561	714,599	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	905	0	905	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	439,943	275,561	715,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACC OUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	13,090					5.01
5.02	00591	PERSONNEL	19	2,696				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	165	107	8,186			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	855	156	0	36,564		5.05
7.00	00700	OPERATION OF PLANT	152	57	0	1,556	84,415	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	95	2,792	8.00
9.00	00900	HOUSEKEEPING	63	56	0	616	1,165	9.00
10.00	01000	DIETARY	70	68	0	751	3,228	10.00
11.00	01100	CAFETERIA	0	0	0	11	1,243	11.00
13.00	01300	NURSING ADMINISTRATION	25	36	0	486	1,289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,193	8	0	242	1,090	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133	84	0	982	2,775	16.00
17.00	01700	SOCIAL SERVICE	6	23	0	232	321	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	627	480	540	5,561	19,584	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,254	120	1,442	1,802	4,926	50.00
53.00	05300	ANESTHESIOLOGY	247	0	116	292	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	513	129	1,100	2,202	3,373	54.00
60.00	06000	LABORATORY	291	148	912	2,562	3,192	60.00
64.00	06400	INTRAVENOUS THERAPY	0	8	274	233	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	70	19	0	65.00
66.00	06600	PHYSICAL THERAPY	348	89	365	982	5,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67	206	717	1,038	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	7	33	256	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	40	32	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76	0	117	252	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	355	1,419	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	209	49	811	1,493	1,014	73.00
76.00	03950	NEUROLOGY	0	0	10	48	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,590	849	1,139	9,210	22,092	88.00
91.00	09100	EMERGENCY	1,691	109	462	4,033	2,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	6	19	36	214	643	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	557	33	184	487	5,911	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,090	2,696	8,186	36,562	84,170	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	2	245	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,090	2,696	8,186	36,564	84,415	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,192					8.00
9.00	00900	HOUSEKEEPING	0	6,201				9.00
10.00	01000	DIETARY	0	35	16,112			10.00
11.00	01100	CAFETERIA	0	0	9,500	15,342		11.00
13.00	01300	NURSING ADMINISTRATION	0	39	0	214	6,847	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110	0	123	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	139	0	1,157	0	16.00
17.00	01700	SOCIAL SERVICE	0	32	0	154	134	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,297	1,937	6,491	4,475	3,896	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,792	346	0	687	598	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772	306	0	1,102	0	54.00
60.00	06000	LABORATORY	0	322	0	1,248	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	22	19	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	519	552	0	571	497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	105	0	332	289	67.00
68.00	06800	SPEECH PATHOLOGY	0	26	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19	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	86	0	296	258	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	984	1,827	0	3,336	0	88.00
91.00	09100	EMERGENCY	2,791	279	0	1,184	1,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	35	0	144	125	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	37	0	0	278	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,192	6,176	15,991	15,342	6,847	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	25	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	121	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,192	6,201	16,112	15,342	6,847	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,789					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,078				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,086			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	994	2,086	156,548	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,176	3,123	0	123,407	0	50.00
53.00	05300	ANESTHESIOLOGY	0	384	0	1,039	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,035	0	142,858	0	54.00
60.00	06000	LABORATORY	0	1,681	0	37,711	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	504	0	1,060	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	128	0	929	0	65.00
66.00	06600	PHYSICAL THERAPY	0	673	0	30,259	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	379	0	6,963	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13	0	1,279	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	96	0	1,832	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	215	0	660	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	653	0	2,427	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,493	0	13,080	0	73.00
76.00	03950	NEUROLOGY	0	29	0	87	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,549	2,098	0	132,619	0	88.00
91.00	09100	EMERGENCY	64	1,174	0	28,141	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	67	0	3,664	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	339	0	29,643	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,789	16,078	2,086	714,206	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	1,177	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	121	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,789	16,078	2,086	715,504	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	5.01
5.02	00591	PERSONNEL	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	NEUROLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	WOUND CARE	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
194.00	07950	OPHTH CLINIC	194.00
194.01	07951	RENTAL SPACE	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1329

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
1.00	2.00	4.00	5.01	5.02				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,866					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		268,182				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,467,193			4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,692	0	53,727	2,067		5.01
5.02	00591	PERSONNEL	346	0	74,500	3	8,449,523	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,023	0	314,500	26	334,867	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	3,072	11,471	484,399	135	489,841	5.05
7.00	00700	OPERATION OF PLANT	10,460	1,680	180,210	24	180,210	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	556	0	174,289	10	174,289	9.00
10.00	01000	DIETARY	1,540	45	213,651	11	213,651	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	113,875	4	113,875	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	23,784	504	23,784	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	550	261,893	21	261,893	16.00
17.00	01700	SOCIAL SERVICE	153	0	71,617	1	71,617	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,343	30,460	1,505,343	99	1,505,343	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,350	79,765	267,527	356	376,480	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	39	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609	115,695	404,645	81	404,645	54.00
60.00	06000	LABORATORY	1,523	15,155	462,954	46	462,954	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	24,612	0	24,612	64.00
65.00	06500	RESPIRATORY THERAPY	0	693	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,610	0	278,653	55	278,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	210,923	0	210,923	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	4,126	0	4,126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12	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	484	3,530	153,151	33	153,151	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,540	5,257	684,524	251	2,660,319	88.00
91.00	09100	EMERGENCY	1,320	2,281	340,495	267	340,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	59,043	1	59,043	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,820	0	104,752	88	104,752	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,749	268,182	6,467,193	2,067	8,449,523	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	439,943	275,561	2,056,102	79,319	109,324	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.736486	1.027515	0.317928	38.373972	0.012938	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	13,090	2,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	6.332850	0.000319	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: 14-1329

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.05	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	27,492,810					5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	-1,367,201	15,257,563			5.05
7.00	00700	OPERATION OF PLANT	0	0	649,444	40,273		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	39,562	1,332	10,447	8.00
9.00	00900	HOUSEKEEPING	0	0	257,242	556	0	9.00
10.00	01000	DIETARY	0	0	313,592	1,540	0	10.00
11.00	01100	CAFETERIA	0	0	4,588	593	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	202,972	615	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	101,075	520	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	409,833	1,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	97,023	153	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,811,157	0	2,320,983	9,343	4,988	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,864,133	0	752,171	2,350	1,419	50.00
53.00	05300	ANESTHESIOLOGY	389,180	0	121,943	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,692,685	0	918,937	1,609	611	54.00
60.00	06000	LABORATORY	3,061,349	0	1,069,289	1,523	0	60.00
64.00	06400	INTRAVENOUS THERAPY	918,243	0	97,282	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	233,596	0	8,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,224,957	0	409,709	2,610	411	66.00
67.00	06700	OCCUPATIONAL THERAPY	690,987	0	299,404	495	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,848	0	13,727	122	0	68.00
69.00	06900	ELECTROCARDIOLOGY	135,850	0	13,312	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,738	0	105,077	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,190,339	0	592,430	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,720,357	0	623,117	484	0	73.00
76.00	03950	NEUROLOGY	34,902	0	19,907	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,821,611	0	3,840,046	10,540	779	88.00
91.00	09100	EMERGENCY	1,550,839	0	1,683,377	1,320	2,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	121,247	0	89,134	307	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	616,792	0	203,402	2,820	29	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,492,810	-1,367,201	15,256,658	40,156	10,447	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	905	117	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	527,348		1,367,201	707,639	66,512	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019181		0.089608	17.571053	6.366612	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,186		36,564	84,415	13,192	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000298		0.002396	2.096069	1.262755	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: 14-1329

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	29,361					9.00
10.00	01000	DIETARY	164	24,675				10.00
11.00	01100	CAFETERIA	0	14,549	9,942			11.00
13.00	01300	NURSING ADMINISTRATION	186	0	139	106,007		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	80	0	4,810	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	657	0	750	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	100	2,080	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,182	9,940	2,900	60,323	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,638	0	445	9,260	3,380	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,450	0	714	0	0	54.00
60.00	06000	LABORATORY	1,523	0	809	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14	298	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,612	0	370	7,698	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	215	4,468	0	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12	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	406	0	192	3,991	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,650	0	2,162	0	1,395	88.00
91.00	09100	EMERGENCY	1,321	0	767	15,960	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	165	0	93	1,929	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	180	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,244	24,489	9,942	106,007	4,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	186	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	290,063	370,371	233,799	237,073	126,287	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.879193	15.009970	23.516295	2.236390	26.255094	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,201	16,112	15,342	6,847	8,789	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.211199	0.652969	1.543150	0.064590	1.827235	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: 14-1329

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00560	PURCHASING RECEIVING AND STORES		5.01
5.02	00591	PERSONNEL		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.05	00590	ADMINISTRATIVE & GENERAL		5.05
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,273,239	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,811,157	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,674,069	50.00
53.00	05300	ANESTHESIOLOGY	699,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,706,860	54.00
60.00	06000	LABORATORY	3,061,349	60.00
64.00	06400	INTRAVENOUS THERAPY	918,243	64.00
65.00	06500	RESPIRATORY THERAPY	233,596	65.00
66.00	06600	PHYSICAL THERAPY	1,224,957	66.00
67.00	06700	OCCUPATIONAL THERAPY	690,987	67.00
68.00	06800	SPEECH PATHOLOGY	22,848	68.00
69.00	06900	ELECTROCARDIOLOGY	175,227	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,738	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,190,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,720,357	73.00
76.00	03950	NEUROLOGY	53,690	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3,821,611	88.00
91.00	09100	EMERGENCY	2,138,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04950	WOUND CARE	121,247	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	616,792	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,273,239	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	OPHTH CLINIC	0	194.00
194.01	07951	RENTAL SPACE	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	493,949	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.016874	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,078	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000549	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

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY		1	30.00	-30,590 7.00
8.00		IV THERAPY		1	64.00	30,590 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

				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	3,284,789		3,284,789	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,101,732		1,101,732	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	144,681		144,681	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,127,109		1,127,109	0	0	54.00	
60.00	06000	LABORATORY	1,277,595		1,277,595	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	153,078		153,078	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	12,746	0	12,746	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	567,290	0	567,290	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	366,529	0	366,529	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	18,692	0	18,692	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	17,744		17,744	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,103		121,103	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	665,602		665,602	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	750,811		750,811	0	0	73.00	
76.00	03950	NEUROLOGY	22,597		22,597	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	4,611,716		4,611,716	0	0	88.00	
91.00	09100	EMERGENCY	1,975,264		1,975,264	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	100,710		100,710	0	0	92.00	
93.00	04950	WOUND CARE	112,692		112,692	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	286,004		286,004	0	0	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	16,718,484	0	16,718,484	0	0	200.00	
201.00		Less Observation Beds	100,710		100,710			201.00	
202.00		Total (see instructions)	16,617,774	0	16,617,774	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,587,154		1,587,154		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,028	4,758,830	4,823,858	0.228392	0.000000
53.00	05300	ANESTHESIOLOGY	7,350	377,878	385,228	0.375572	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,698	3,556,005	3,654,703	0.308400	0.000000
60.00	06000	LABORATORY	243,978	2,790,527	3,034,505	0.421023	0.000000
64.00	06400	INTRAVENOUS THERAPY	210,686	705,838	916,524	0.167020	0.000000
65.00	06500	RESPIRATORY THERAPY	188,058	45,456	233,514	0.054583	0.000000
66.00	06600	PHYSICAL THERAPY	736,311	475,808	1,212,119	0.468015	0.000000
67.00	06700	OCCUPATIONAL THERAPY	566,192	124,795	690,987	0.530443	0.000000
68.00	06800	SPEECH PATHOLOGY	14,830	5,691	20,521	0.910872	0.000000
69.00	06900	ELECTROCARDIOLOGY	4,807	129,789	134,596	0.131832	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	260,928	129,484	390,412	0.310193	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,453	1,124,864	1,184,317	0.562013	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,866	1,163,851	2,715,717	0.276469	0.000000
76.00	03950	NEUROLOGY	0	34,902	34,902	0.647441	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	160,349	3,638,033	3,798,382		
91.00	09100	EMERGENCY	177	1,543,540	1,543,717	1.279551	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	224,003	224,003	0.449592	0.000000
93.00	04950	WOUND CARE	8,579	112,381	120,960	0.931647	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	616,792	616,792	0.463696	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	5,764,444	21,558,467	27,322,911		
201.00		Less Observation Beds					
202.00		Total (see instructions)	5,764,444	21,558,467	27,322,911		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,284,789		3,284,789	0	3,284,789	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,101,732		1,101,732	0	1,101,732	50.00
53.00	05300	ANESTHESIOLOGY	144,681		144,681	0	144,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,127,109		1,127,109	0	1,127,109	54.00
60.00	06000	LABORATORY	1,277,595		1,277,595	0	1,277,595	60.00
64.00	06400	INTRAVENOUS THERAPY	153,078		153,078	0	153,078	64.00
65.00	06500	RESPIRATORY THERAPY	12,746	0	12,746	0	12,746	65.00
66.00	06600	PHYSICAL THERAPY	567,290	0	567,290	0	567,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,529	0	366,529	0	366,529	67.00
68.00	06800	SPEECH PATHOLOGY	18,692	0	18,692	0	18,692	68.00
69.00	06900	ELECTROCARDIOLOGY	17,744		17,744	0	17,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,103		121,103	0	121,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	665,602		665,602	0	665,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	750,811		750,811	0	750,811	73.00
76.00	03950	NEUROLOGY	22,597		22,597	0	22,597	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,611,716		4,611,716	0	4,611,716	88.00
91.00	09100	EMERGENCY	1,975,264		1,975,264	0	1,975,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	100,710		100,710		100,710	92.00
93.00	04950	WOUND CARE	112,692		112,692	0	112,692	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	286,004		286,004	0	286,004	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,718,484	0	16,718,484	0	16,718,484	200.00
201.00		Less Observation Beds	100,710		100,710		100,710	201.00
202.00		Total (see instructions)	16,617,774	0	16,617,774	0	16,617,774	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,587,154		1,587,154		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,028	4,758,830	4,823,858	0.228392	50.00
53.00	05300	ANESTHESIOLOGY	7,350	377,878	385,228	0.375572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,698	3,556,005	3,654,703	0.308400	54.00
60.00	06000	LABORATORY	243,978	2,790,527	3,034,505	0.421023	60.00
64.00	06400	INTRAVENOUS THERAPY	210,686	705,838	916,524	0.167020	64.00
65.00	06500	RESPIRATORY THERAPY	188,058	45,456	233,514	0.054583	65.00
66.00	06600	PHYSICAL THERAPY	736,311	475,808	1,212,119	0.468015	66.00
67.00	06700	OCCUPATIONAL THERAPY	566,192	124,795	690,987	0.530443	67.00
68.00	06800	SPEECH PATHOLOGY	14,830	5,691	20,521	0.910872	68.00
69.00	06900	ELECTROCARDIOLOGY	4,807	129,789	134,596	0.131832	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	260,928	129,484	390,412	0.310193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,453	1,124,864	1,184,317	0.562013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,866	1,163,851	2,715,717	0.276469	73.00
76.00	03950	NEUROLOGY	0	34,902	34,902	0.647441	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	160,349	3,638,033	3,798,382	1.214126	88.00
91.00	09100	EMERGENCY	177	1,543,540	1,543,717	1.279551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	224,003	224,003	0.449592	92.00
93.00	04950	WOUND CARE	8,579	112,381	120,960	0.931647	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	616,792	616,792	0.463696	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,764,444	21,558,467	27,322,911		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,764,444	21,558,467	27,322,911		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	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: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	123,407	4,823,858	0.025583	984	25 50.00
53.00	05300	ANESTHESIOLOGY	1,039	385,228	0.002697	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,858	3,654,703	0.039089	12,577	492 54.00
60.00	06000	LABORATORY	37,711	3,034,505	0.012427	28,476	354 60.00
64.00	06400	INTRAVENOUS THERAPY	1,060	916,524	0.001157	23,378	27 64.00
65.00	06500	RESPIRATORY THERAPY	929	233,514	0.003978	20,315	81 65.00
66.00	06600	PHYSICAL THERAPY	30,259	1,212,119	0.024964	3,387	85 66.00
67.00	06700	OCCUPATIONAL THERAPY	6,963	690,987	0.010077	2,889	29 67.00
68.00	06800	SPEECH PATHOLOGY	1,279	20,521	0.062326	210	13 68.00
69.00	06900	ELECTROCARDIOLOGY	1,832	134,596	0.013611	1,254	17 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	660	390,412	0.001691	18,248	31 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,427	1,184,317	0.002049	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,080	2,715,717	0.004816	40,883	197 73.00
76.00	03950	NEUROLOGY	87	34,902	0.002493	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	132,619	3,798,382	0.034915	0	0 88.00
91.00	09100	EMERGENCY	28,141	1,543,717	0.018229	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,800	224,003	0.021428	0	0 92.00
93.00	04950	WOUND CARE	3,664	120,960	0.030291	936	28 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	532,815	25,118,965		153,537	1,379 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00	04950	WOUND CARE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 2:13 pm

				Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,823,858	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	385,228	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,654,703	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	3,034,505	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	916,524	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	233,514	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	1,212,119	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	690,987	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	20,521	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	134,596	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	390,412	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,184,317	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,715,717	0.000000	73.00	
76.00	03950	NEUROLOGY	0	0	0	34,902	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,798,382	0.000000	88.00	
91.00	09100	EMERGENCY	0	0	0	1,543,717	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	224,003	0.000000	92.00	
93.00	04950	WOUND CARE	0	0	0	120,960	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	0	0	0	25,118,965		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	984	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,577	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	28,476	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	23,378	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	20,315	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,387	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,889	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	210	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,254	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	18,248	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	40,883	0	0	0	73.00
76.00	03950	NEUROLOGY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	WOUND CARE	0.000000	936	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		153,537	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/19/2019 2:13 pm

			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	0.228392	0	1,582,144	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.375572	0	122,722	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.308400	0	970,351	0	0	54.00
60.00	06000	LABORATORY	0.421023	0	739,107	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167020	0	251,457	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.054583	0	22,656	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468015	0	188,491	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.530443	0	63,422	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.910872	0	3,734	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131832	0	42,845	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.310193	0	54,513	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562013	0	562,583	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276469	0	420,408	0	0	73.00
76.00	03950	NEUROLOGY	0.647441	0	10,501	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.279551	0	414,076	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.449592	0	120,661		0	92.00
93.00	04950	WOUND CARE	0.931647	0	56,715	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.463696		0			95.00
200.00		Subtotal (see instructions)		0	5,626,386	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	5,626,386	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	361,349	0		50.00
53.00	05300	ANESTHESIOLOGY	46,091	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,256	0		54.00
60.00	06000	LABORATORY	311,181	0		60.00
64.00	06400	INTRAVENOUS THERAPY	41,998	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,237	0		65.00
66.00	06600	PHYSICAL THERAPY	88,217	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,642	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,401	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,648	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,910	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	316,179	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,230	0		73.00
76.00	03950	NEUROLOGY	6,799	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	529,831	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	54,248	0		92.00
93.00	04950	WOUND CARE	52,838	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,285,055	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,285,055	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329

Period:

Worksheet D

Component CCN: 14-Z329

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XVIII	Swing Beds - SNF		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.228392	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.375572	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.308400	0	0	0	54.00
60.00	06000	LABORATORY	0.421023	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167020	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.054583	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468015	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.530443	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.910872	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.131832	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.310193	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.562013	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276469	0	0	0	73.00
76.00	03950	NEUROLOGY	0.647441	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
91.00	09100	EMERGENCY	1.279551	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.449592	0	0	0	92.00
93.00	04950	WOUND CARE	0.931647	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.463696		0		95.00
200.00		Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329

Period:

Worksheet D

Component CCN: 14-Z329

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/19/2019 2:13 pm

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	NEUROLOGY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	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: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/19/2019 2:13 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,427 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			240 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)			150 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,308 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)			1,307 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			286 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)			286 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			71 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)			1,017 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)			1,017 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,284,789 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)			44,956 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)			44,956 25.00
26.00	Total swing-bed cost (see instructions)			3,016,228 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			268,561 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)			268,561 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)			1,119.05 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			79,453 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)			79,453 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1329

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

Worksheet D-1

Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					42,415 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					121,868 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)					1,138,074 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,138,074 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,276,148 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)					90 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,119.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					100,710 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1329

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

Worksheet D-1

Date/Time Prepared:
11/19/2019 2:13 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	156,548	3,284,789	0.047658	100,710	4,800	90.00
91.00	Nursing School cost	0	3,284,789	0.000000	100,710	0	91.00
92.00	Allied health cost	0	3,284,789	0.000000	100,710	0	92.00
93.00	All other Medical Education	0	3,284,789	0.000000	100,710	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/19/2019 2:13 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		68,870		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.228392	984	225	50.00
53.00	05300 ANESTHESIOLOGY	0.375572	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.308400	12,577	3,879	54.00
60.00	06000 LABORATORY	0.421023	28,476	11,989	60.00
64.00	06400 INTRAVENOUS THERAPY	0.167020	23,378	3,905	64.00
65.00	06500 RESPIRATORY THERAPY	0.054583	20,315	1,109	65.00
66.00	06600 PHYSICAL THERAPY	0.468015	3,387	1,585	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.530443	2,889	1,532	67.00
68.00	06800 SPEECH PATHOLOGY	0.910872	210	191	68.00
69.00	06900 ELECTROCARDIOLOGY	0.131832	1,254	165	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.310193	18,248	5,660	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.562013	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276469	40,883	11,303	73.00
76.00	03950 NEUROLOGY	0.647441	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.279551	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.449592	0	0	92.00
93.00	04950 WOUND CARE	0.931647	936	872	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)		153,537	42,415	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)		153,537		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1329 Component CCN: 14-Z329	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/19/2019 2:13 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.228392	11,119	2,539	50.00
53.00	05300 ANESTHESIOLOGY	0.375572	1,276	479	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.308400	32,954	10,163	54.00
60.00	06000 LABORATORY	0.421023	130,280	54,851	60.00
64.00	06400 INTRAVENOUS THERAPY	0.167020	122,556	20,469	64.00
65.00	06500 RESPIRATORY THERAPY	0.054583	152,478	8,323	65.00
66.00	06600 PHYSICAL THERAPY	0.468015	505,124	236,406	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.530443	400,351	212,363	67.00
68.00	06800 SPEECH PATHOLOGY	0.910872	7,454	6,790	68.00
69.00	06900 ELECTROCARDIOLOGY	0.131832	1,672	220	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.310193	183,923	57,052	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.562013	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276469	884,477	244,530	73.00
76.00	03950 NEUROLOGY	0.647441	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.279551	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.449592	0	0	92.00
93.00	04950 WOUND CARE	0.931647	2,369	2,207	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)		2,436,033	856,392	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)		2,436,033		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/19/2019 2:13 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,285,055 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,285,055 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			2,307,906 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)			14,310 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			983,806 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,309,790 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,309,790 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			1,309,790 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)			47,322 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			30,759 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			42,812 36.00
37.00	Subtotal (see instructions)			1,340,549 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)			1,340,549 40.00
40.01	Sequestration adjustment (see instructions)			26,811 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			1,532,920 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-219,182 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			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: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/19/2019 2:13 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		88,777		1,813,118	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/20/2019	2,477	06/20/2019	183,376	3.50
3.51		12/19/2018	1,169	12/19/2018	96,822	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)		-3,646		-280,198	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)		85,131		1,532,920	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		4,869		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		219,182	6.02
7.00	Total Medicare program liability (see instructions)		90,000		1,313,738	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1329

Period:

Worksheet E-1

Component CCN: 14-Z329

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/19/2019 2:13 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,166,959		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	12/19/2018	27,815		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/20/2019	157,581		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)		-129,766		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)		3,037,193		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		11,888		0	6.02
7.00	Total Medicare program liability (see instructions)		3,025,305		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/19/2019 2:13 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2
		Component CCN: 14-Z329		Date/Time Prepared: 11/19/2019 2:13 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,298,909	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)		864,956	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		2,034	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)		3,163,865	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		3,163,865	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)		3,163,865	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		76,846	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)		3,087,019	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)		41	0 17.00
17.01	Adjusted reimbursable bad debts (see instructions)		27	0 17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (see instructions)		3,087,046	0 19.00
19.01	Sequestration adjustment (see instructions)		61,741	0 19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0 19.02
20.00	Interim payments		3,037,193	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)		-11,888	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: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/19/2019 2:13 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		121,868	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)		121,868	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		121,868	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)		121,868	19.00
20.00	Deductibles (exclude professional component)		31,012	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		90,856	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		90,856	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,509	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		981	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		91,837	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)		91,837	30.00
30.01	Sequestration adjustment (see instructions)		1,837	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		85,131	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)		4,869	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: 14-1329

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

Worksheet G

Date/Time Prepared:
11/19/2019 2:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,238,494	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	4,797,915	0	0	0	4.00
5.00	Other receivable	1,169,320	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	327,200	0	0	0	7.00
8.00	Prepaid expenses	63,381	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,596,310	0	0	0	11.00
FIXED ASSETS						
12.00	Land	214,162	0	0	0	12.00
13.00	Land improvements	429,924	0	0	0	13.00
14.00	Accumulated depreciation	-320,584	0	0	0	14.00
15.00	Buildings	12,336,456	0	0	0	15.00
16.00	Accumulated depreciation	-6,233,485	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	939,479	0	0	0	19.00
20.00	Accumulated depreciation	-654,166	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,083,345	0	0	0	23.00
24.00	Accumulated depreciation	-4,632,144	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,162,987	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	19,771	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,771	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,779,068	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,392,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	523,496	0	0	0	38.00
39.00	Payroll taxes payable	269,504	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,012,346	0	0	0	40.00
41.00	Deferred income	625,275	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	479,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,302,002	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,130,946	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,130,946	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,432,948	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,346,120	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,346,120	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,779,068	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1329

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

Worksheet G-1

Date/Time Prepared:
11/19/2019 2:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,109,923		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,236,197				2.00
3.00	Total (sum of line 1 and line 2)		7,346,120		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		7,346,120		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)		7,346,120		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1329

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2019 2:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	385,296		385,296	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,394,737		1,394,737	5.00
6.00	Swing bed - NF	46,276		46,276	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,826,309		1,826,309	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,826,309		1,826,309	17.00
18.00	Ancillary services	4,019,641	16,729,422	20,749,063	18.00
19.00	Outpatient services	8,756	2,250,707	2,259,463	19.00
20.00	RURAL HEALTH CLINIC	160,349	3,661,262	3,821,611	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	616,792	616,792	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,015,055	23,258,183	29,273,238	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,530,880		29.00
30.00	CHARITY CARE RHC SLIDING FEE	4,529			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)		4,529		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,535,409		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1329

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

Worksheet G-3

Date/Time Prepared:
11/19/2019 2:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,273,238	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,838,402	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,434,836	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,535,409	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-100,573	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,500	6.00
7.00	Income from investments	25,760	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	140,706	24.00
24.01	COUNTY TAX REVENUE	1,191,725	24.01
24.02	STATE TAX REVENUE	86,309	24.02
24.03	ROUNDING	0	24.03
25.00	Total other income (sum of lines 6-24)	1,447,000	25.00
26.00	Total (line 5 plus line 25)	1,346,427	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	86,203	27.00
27.01	CHARITY CARE	24,027	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	110,230	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,236,197	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329

Period:

Worksheet M-1

Component CCN: 14-3981

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 2:13 pm

		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	1,745,604	0	1,745,604	0	1,745,604
2.00	Physician Assistant	85,410	0	85,410	0	85,410
3.00	Nurse Practitioner	117,325	0	117,325	0	117,325
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	136,410	0	136,410	0	136,410
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	575,571	0	575,571	0	575,571
10.00	Subtotal (sum of lines 1 through 9)	2,660,320	0	2,660,320	0	2,660,320
11.00	Physician Services Under Agreement	0	489,565	489,565	0	489,565
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	489,565	489,565	0	489,565
15.00	Medical Supplies	0	33,410	33,410	0	33,410
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	28,255	28,255	-28,254	1
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	61,665	61,665	-28,254	33,411
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,660,320	551,230	3,211,550	-28,254	3,183,296
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	29,514	29,514	0	29,514
30.00	Administrative Costs	0	59,081	59,081	232,147	291,228
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	88,595	88,595	232,147	320,742
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,660,320	639,825	3,300,145	203,893	3,504,038

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329

Period:

Worksheet M-1

Component CCN: 14-3981

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 2:13 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,745,604		1.00
2.00	Physician Assistant	0	85,410		2.00
3.00	Nurse Practitioner	-56,119	61,206		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	136,410		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	575,571		9.00
10.00	Subtotal (sum of lines 1 through 9)	-56,119	2,604,201		10.00
11.00	Physician Services Under Agreement	0	489,565		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	489,565		14.00
15.00	Medical Supplies	0	33,410		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	1		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	33,411		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-56,119	3,127,177		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	29,514		29.00
30.00	Administrative Costs	-29,805	261,423		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-29,805	290,937		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-85,924	3,418,114		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1329

Period:

Worksheet M-2

Component CCN: 14-3981

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 2:13 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	5.21	15,511	4,200	21,882	1.00
2.00	Physician Assistant	0.69	2,604	2,100	1,449	2.00
3.00	Nurse Practitioner	0.32	1,138	2,100	672	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.22	19,253		24,003	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	1.83	2,265		2,265	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)	8.05	21,518		26,268	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)				3,127,177	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)				3,127,177	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)				290,937	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,193,602	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,484,539	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,484,539	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,484,539	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,611,716	20.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1329	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-3981		Date/Time Prepared: 11/19/2019 2:13 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,611,716	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,940	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,592,776	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			26,268	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)			26,268	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			174.84	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		174.84	174.84	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,601	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	629,599	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	265	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	46,333	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	46,333	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	675,932	16.00
16.01	Total program charges (see instructions)(from contractor's records)			754,184	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,887	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,587	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.)			516,782	16.04
16.05	Total program cost (see instructions)		0	519,369	16.05
17.00	Primary payer amounts			113	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			27,368	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			144,786	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			519,256	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,924	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			521,180	22.00
23.00	Allowable bad debts (see instructions)			4,208	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,735	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,560	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)			523,915	26.00
26.01	Sequestration adjustment (see instructions)			10,478	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			502,226	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)			11,211	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: 14-1329 Component CCN: 14-3981	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/19/2019 2:13 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,604,201	2,604,201	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000152	0.000634	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		396	1,651	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,129	4,667	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,525	6,318	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,127,177	3,127,177	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,484,539	1,484,539	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002087	0.002020	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,098	2,999	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		9,623	9,317	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		41	171	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		234.71	54.49	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		235	1,689	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)			18,940	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			1,924	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/19/2019 2:13 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		481,545	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		06/30/2019	12,373		3.01
3.02		12/19/2019	8,308		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)		20,681		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		502,226		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		11,211		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		513,437		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00