

State Copy

Health Financial Systems

MARSHALL BROWNING HOSPITAL

In Lieu of Form CMS-2552-10

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: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 10:19 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 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.	Date:	Time:
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 MARSHALL BROWNING HOSPITAL (14-1331) 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title XVIII			HIT	Title XIX	
		Title V	Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	-79,053	298,921	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	-127,342	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		78,936		0	10.00
10.01	RURAL HEALTH CLINIC II - FHC	0		83,856		0	10.01
200.00	Total	0	-206,395	461,713	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: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:19 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 900 NORTH WASHINGTON STREET			PO Box:				1.00	
2.00	City: DUQUOIN			State: IL		Zip Code: 62832		County: PERRY	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MARSHALL BROWNING HOSPITAL	141331	99914	1	01/01/2004	N	O
4.00	Subprovider - IPF								P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MARSHALL BROWNING SWING BED	14Z331	99914		01/01/2004	N	O
8.00	Swing Beds - NF								N
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		MARSHALL BROWNING PHYSICIAN CLINIC	148504	99914		05/01/2009	N	O
15.01	Hospital-Based Health Clinic - RHC II		MARSHALL BROWNING FAMILY HEALTH CENTE	148597	99914		06/28/2018	N	O
16.00	Hospital-Based Health Clinic - FQHC								N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1331

Period:
From 07/01/2018
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Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:19 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under \$413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	Y	N
					N
					4.00
					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: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:19 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	330,838	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:19 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.					Y		02/07/2019	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.							Y	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.							Y	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	Y	Y	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							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)								0168.00
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)							Y	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: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 10:19 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	10/28/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	11/05/2019	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: 14-1331

Period:
From 07/01/2018
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Part II
Date/Time Prepared:
11/25/2019 10:19 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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.	ANDREW	MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586660	AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1331

Period:
From 07/01/2018
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Date/Time Prepared:
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		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.	CPA		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

Health Financial Systems		MARSHALL BROWNING HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part IX Date/Time Prepared: 11/25/2019 10:19 pm	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00	
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00	
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00	
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01	
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00	
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00	
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00	
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00	
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00	
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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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	20,760.00	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	20,760.00	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	20,760.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II - FHC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:19 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)	677	10	865			1.00
2.00	HMO and other (see instructions)	0	36				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	891	0	1,058			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	188			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,568	10	2,111			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,568	10	2,111	0.00	182.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,650	0	11,677	0.00	18.72	26.00
26.01	RURAL HEALTH CLINIC II - FHC	757	0	4,718	0.00	8.65	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	210.25	27.00
28.00	Observation Bed Days		0	339			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:19 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	201	3	386	1.00
2.00 HMO and other (see instructions)			0	14		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	201	3	386	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II - FHC	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1331 Component CCN: 14-8504		Period: From 07/01/2018 To 06/30/2019
			Worksheet S-8		Date/Time Prepared: 11/25/2019 10:19 pm
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		900 N. WASHINGTON		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		DU QUOIN IL 62832		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		9.00		
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
			Sunday		Monday
			from to		Tuesday
			1.00 2.00		from
			3.00 4.00		5.00
Facility hours of operations (1)					
11.00	CLINIC		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 XIX
			1.00 2.00		3.00 4.00
					Total Visits
					5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		15.00		
			County		
			4.00		
2.00	City, State, ZIP Code, County		PERRY		2.00
			Tuesday		Wednesday
			to from to		Thursday
			6.00 7.00 8.00		9.00 10.00
Facility hours of operations (1)					
11.00	CLINIC		16:30	08:00	16:30
			08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1331
Component CCN: 14-8504Period:
From 07/01/2018
To 06/30/2019

Worksheet S-8

Date/Time Prepared:
11/25/2019 10:19 pm

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

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1331 Component CCN: 14-8597		Period: From 07/01/2018 To 06/30/2019
			Worksheet S-8		Date/Time Prepared: 11/25/2019 10:19 pm
			RHC II		Cost
			1.00		
1.00	Clinic Address and Identification			20 N. WASHINGTON	
	Street			1.00	
	City			State	ZIP Code
	1.00			2.00	3.00
2.00	City, State, ZIP Code, County			DU QUION	IL 62832
				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
			Sunday		Tuesday
			from	to	from
			1.00	2.00	3.00
Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number			Total Visits	
			Y/N	V	XVIII
			1.00	2.00	3.00
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			PERRY	
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
Facility hours of operations (1)					
11.00	CLINIC			16:30	08:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1331

Period:

Worksheet S-8

Component CCN: 14-8597

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1331

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

Worksheet S-10

Date/Time Prepared:
11/25/2019 10:19 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)		0.499632	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,083,478	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		9,109,331	6.00
7.00	Medicaid cost (line 1 times line 6)		4,551,313	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)		467,835	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)		467,835	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	308,117	0	308,117 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	153,945	0	153,945 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	153,945	0	153,945 23.00
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,015,126	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		155,575	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		239,346	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,775,780	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		971,008	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,124,953	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,592,788	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1331

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

Worksheet A

Date/Time Prepared:
11/25/2019 10:19 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		696,328	696,328	372,423	1,068,751	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		758,613	758,613	-7,122	751,491	2.00
3.00	00300	OTHER CAP REL COSTS		102,905	102,905	-102,905	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,173,660	3,173,660	-123,081	3,050,579	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,373,360	2,440,432	3,813,792	0	3,813,792	5.00
6.00	00600	MAINTENANCE & REPAIRS	188,737	182,270	371,007	0	371,007	6.00
7.00	00700	OPERATION OF PLANT	0	257,209	257,209	0	257,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,392	53,298	68,690	0	68,690	8.00
9.00	00900	HOUSEKEEPING	330,598	50,735	381,333	0	381,333	9.00
10.00	01000	DIETARY	244,267	158,250	402,517	0	402,517	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	464,234	25,359	489,593	0	489,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	268,176	1,214,284	1,482,460	0	1,482,460	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	426,853	74,010	500,863	0	500,863	16.00
17.00	01700	SOCIAL SERVICE	297	0	297	0	297	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,273,513	979,028	2,252,541	0	2,252,541	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	476,750	184,068	660,818	25,265	686,083	50.00
53.00	05300	ANESTHESIOLOGY	0	201,287	201,287	0	201,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	608,564	706,599	1,315,163	0	1,315,163	54.00
60.00	06000	LABORATORY	478,479	736,646	1,215,125	0	1,215,125	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	405,510	57,572	463,082	0	463,082	65.00
66.00	06600	PHYSICAL THERAPY	673,273	112,299	785,572	-188,656	596,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	108,482	108,482	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	80,174	80,174	68.00
69.00	06900	ELECTROCARDIOLOGY	40,789	11,429	52,218	0	52,218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	323,130	323,130	0	323,130	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	99,593	1,589	101,182	0	101,182	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,442,320	408,235	1,850,555	-24,481	1,826,074	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	387,367	103,427	490,794	240,811	731,605	88.01
90.00	09000	CLINIC	27,200	697,202	724,402	201,101	925,503	90.00
91.00	09100	EMERGENCY	730,706	1,161,732	1,892,438	0	1,892,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		428,467	428,467	-428,467	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,955,978	15,300,063	25,256,041	153,544	25,409,585	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	367,785	34,415	402,200	-201,101	201,099	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	92,298	132,050	224,348	47,557	271,905	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	10,416,061	15,466,528	25,882,589	0	25,882,589	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1331

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

Worksheet A

Date/Time Prepared:
11/25/2019 10:19 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	-358	1,068,393	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-282,084	469,407	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,050,579	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-693,175	3,120,617	5.00
6.00	00600	MAINTENANCE & REPAIRS	-1,464	369,543	6.00
7.00	00700	OPERATION OF PLANT	0	257,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-333	68,357	8.00
9.00	00900	HOUSEKEEPING	-414	380,919	9.00
10.00	01000	DIETARY	-52,640	349,877	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-1,177	488,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-101,138	1,381,322	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,244	499,619	16.00
17.00	01700	SOCIAL SERVICE	0	297	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-889,242	1,363,299	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-158,913	527,170	50.00
53.00	05300	ANESTHESIOLOGY	0	201,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,979	1,313,184	54.00
60.00	06000	LABORATORY	-4,708	1,210,417	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-10,797	452,285	65.00
66.00	06600	PHYSICAL THERAPY	-1,362	595,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,482	67.00
68.00	06800	SPEECH PATHOLOGY	-42,913	37,261	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-31,870	291,260	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	-2,208	98,974	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,820	1,824,254	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	731,605	88.01
90.00	09000	CLINIC	-702,182	223,321	90.00
91.00	09100	EMERGENCY	-1,828	1,890,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,983,849	22,425,736	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-1,640	199,459	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	192.01
192.02	19202	INDEPENDENT LIVING	-1,575	270,330	192.02
192.03	19203	MEALS ON WHEELS	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,987,064	22,895,525	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet Non-CMS W
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Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
20.00	NURSING SCHOOL	02000		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	06250		62.30
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	CARDIAC REHABILITATION	07301		73.01
76.97	CARDIAC REHABILITATION	07697		76.97
76.98	HYPERBARIC OXYGEN THERAPY	07698		76.98
76.99	LITHOTRIPSY	07699		76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II - FHC	08801		88.01
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	FAMILY MEDICAL CLINIC	19201		192.01
192.02	INDEPENDENT LIVING	19202		192.02
192.03	MEALS ON WHEELS	19203		192.03
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1331

Period:
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Worksheet A-6

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - TO RECLASS INTEREST EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	414,006	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,461	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	428,467		
	F - TO RECLASS DEPRECIATION EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	78,245	1.00	
2.00	RURAL HEALTH CLINIC II - FHC	88.01	0	40,269	2.00	
3.00	INDEPENDENT LIVING	192.02	0	47,557	3.00	
	TOTALS		0	166,071		
	G - RECLASS PT COSTS TO OT & SP					
1.00	OCCUPATIONAL THERAPY	67.00	107,629	853	1.00	
2.00	SPEECH PATHOLOGY	68.00	80,174	0	2.00	
	TOTALS		187,803	853		
	H - RECLASS PHYSICIAN BENEFITS					
1.00	OPERATING ROOM	50.00	0	25,265	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	69,588	2.00	
3.00	RURAL HEALTH CLINIC II - FHC	88.01	0	28,228	3.00	
	TOTALS		0	123,081		
	I - RECLASS SPECIALTY CLINIC STAFFING					
1.00	CLINIC	90.00	183,893	17,208	1.00	
	TOTALS		183,893	17,208		
	J - RECLASS MD SERVING NEW RHC II					
1.00	RURAL HEALTH CLINIC II - FHC	88.01	172,314	0	1.00	
	TOTALS		172,314	0		
500.00	Grand Total: Increases		544,010	735,680	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1331

Period:
From 07/01/2018
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Worksheet A-6

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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
C - TO RECLASS INTEREST EXP						
1.00	INTEREST EXPENSE	113.00	0	428,467	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	428,467		
F - TO RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,717	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	54,354	9	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	166,071		
G - RECLASS PT COSTS TO OT & SP						
1.00	PHYSICAL THERAPY	66.00	187,803	853	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		187,803	853		
H - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	123,081	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	123,081		
I - RECLASS SPECIALTY CLINIC STAFFING						
1.00	PHYSICIANS PRIVATE OFFICES	192.00	183,893	17,208	0	1.00
	TOTALS		183,893	17,208		
J - RECLASS MD SERVING NEW RHC II						
1.00	RURAL HEALTH CLINIC	88.00	172,314	0	0	1.00
	TOTALS		172,314	0		
500.00	Grand Total: Decreases		544,010	735,680		500.00

RECLASSIFICATIONS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	C - TO RECLASS INTEREST EXP								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	414,006	INTEREST EXPENSE	113.00	0	428,467	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,461		0.00	0	0	2.00
	TOTALS		0	428,467	TOTALS		0	428,467	
	F - TO RECLASS DEPRECIATION EXPENSE								
1.00	RURAL HEALTH CLINIC	88.00	0	78,245	CAP REL COSTS-BLDG & FIXT	1.00	0	111,717	1.00
2.00	RURAL HEALTH CLINIC II - FHC	88.01	0	40,269	CAP REL COSTS-MVBLE EQUIP	2.00	0	54,354	2.00
3.00	INDEPENDENT LIVING	192.02	0	47,557		0.00	0	0	3.00
	TOTALS		0	166,071	TOTALS		0	166,071	
	G - RECLASS PT COSTS TO OT & SP								
1.00	OCCUPATIONAL THERAPY	67.00	107,629	853	PHYSICAL THERAPY	66.00	187,803	853	1.00
2.00	SPEECH PATHOLOGY	68.00	80,174	0		0.00	0	0	2.00
	TOTALS		187,803	853	TOTALS		187,803	853	
	H - RECLASS PHYSICIAN BENEFITS								
1.00	OPERATING ROOM	50.00	0	25,265	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	123,081	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	69,588		0.00	0	0	2.00
3.00	RURAL HEALTH CLINIC II - FHC	88.01	0	28,228		0.00	0	0	3.00
	TOTALS		0	123,081	TOTALS		0	123,081	
	I - RECLASS SPECIALTY CLINIC STAFFING								
1.00	CLINIC	90.00	183,893	17,208	PHYSICIANS PRIVATE OFFICES	192.00	183,893	17,208	1.00
	TOTALS		183,893	17,208	TOTALS		183,893	17,208	
	J - RECLASS MD SERVING NEW RHC II								
1.00	RURAL HEALTH CLINIC II - FHC	88.01	172,314	0	RURAL HEALTH CLINIC	88.00	172,314	0	1.00
	TOTALS		172,314	0	TOTALS		172,314	0	
500.00	Grand Total: Increases		544,010	735,680	Grand Total: Decreases		544,010	735,680	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,116	0	0	0	2	1.00	
2.00	Land Improvements	1,260,841	0	0	0	0	2.00	
3.00	Buildings and Fixtures	7,412,668	264,334	0	264,334	2,833	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	6,767,218	15,628	0	15,628	96,479	5.00	
6.00	Movable Equipment	5,996,890	473,687	0	473,687	756,914	6.00	
7.00	HIT designated Assets	1,586,972	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	23,027,705	753,649	0	753,649	856,228	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	23,027,705	753,649	0	753,649	856,228	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,114	0				1.00	
2.00	Land Improvements	1,260,841	0				2.00	
3.00	Buildings and Fixtures	7,674,169	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	6,686,367	0				5.00	
6.00	Movable Equipment	5,713,663	0				6.00	
7.00	HIT designated Assets	1,586,972	0				7.00	
8.00	Subtotal (sum of lines 1-7)	22,925,126	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	22,925,126	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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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	696,328	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	758,613	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,454,941	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	696,328				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	758,613				2.00
3.00	Total (sum of lines 1-2)	0	1,454,941				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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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	15,624,491	0	15,624,491	0.681544	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,300,635	0	7,300,635	0.318456	0	2.00
3.00	Total (sum of lines 1-2)	22,925,126	0	22,925,126	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	70,134	70,134	584,611	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	32,771	32,771	423,250	0	2.00
3.00	Total (sum of lines 1-2)	0	102,905	102,905	1,007,861	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	413,648	0	0	70,134	1,068,393	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,386	0	0	32,771	469,407	2.00
3.00	Total (sum of lines 1-2)	427,034	0	0	102,905	1,537,800	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1331

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

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:19 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-281,009	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00 MISCELLANEOUS INCOME	B	-85,282	ADMINISTRATIVE & GENERAL	5.00	0	33.00
36.00 IHA/AHA DUES USED FOR LOBBYING	A	-10,042	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 MARKETING	A	-130,493	ADMINISTRATIVE & GENERAL	5.00	0	37.00
41.00 DEPRECIATION	A	-11,198	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00 DEPRECIATION	A	-1,464	MAINTENANCE & REPAIRS	6.00	0	43.00
44.00 DEPRECIATION	A	-333	LAUNDRY & LINEN SERVICE	8.00	0	44.00
45.00 DEPRECIATION	A	-414	HOUSEKEEPING	9.00	0	45.00
45.01 DEPRECIATION	A	-901	DIETARY	10.00	0	45.01
45.02 DEPRECIATION	A	-1,177	NURSING ADMINISTRATION	13.00	0	45.02
45.03 DEPRECIATION	A	-1,064	PHARMACY	15.00	0	45.03
45.04 DEPRECIATION	A	-412	MEDICAL RECORDS & LIBRARY	16.00	0	45.04
45.05 DEPRECIATION	A	-2,907	ADULTS & PEDIATRICS	30.00	0	45.05
45.06 DEPRECIATION	A	-2,638	OPERATING ROOM	50.00	0	45.06
45.07 DEPRECIATION	A	-1,979	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08 DEPRECIATION	A	-4,708	LABORATORY	60.00	0	45.08
45.09 DEPRECIATION	A	-905	RESPIRATORY THERAPY	65.00	0	45.09
45.10 DEPRECIATION	A	-1,362	PHYSICAL THERAPY	66.00	0	45.10
45.11 DEPRECIATION	A	-2,208	CARDIAC REHABILITATION	73.01	0	45.11
45.12 DEPRECIATION	A	-1,820	RURAL HEALTH CLINIC	88.00	0	45.12
45.13 DEPRECIATION	A	-1,828	EMERGENCY	91.00	0	45.13
46.00 DEPRECIATION	A	-1,640	PHYSICIANS PRIVATE OFFICES	192.00	0	46.00
46.01 DEPRECIATION	A	-1,575	INDEPENDENT LIVING	192.02	0	46.01
47.00 PROVIDER TAX ASSESSMENT	A	-456,160	ADMINISTRATIVE & GENERAL	5.00	0	47.00
47.01 DIABETES EDUCATION	B	-3,875	DIETARY	10.00	0	47.01
47.02 CONTRACTED THERAPY EXPENSES	A	-42,913	SPEECH PATHOLOGY	68.00	0	47.02
47.03 UNECESSARY BORROWING ADJ	A	-1,075	CAP REL COSTS-MVBLE EQUIP	2.00	11	47.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,987,064				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: 14-1331

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2019 10:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	886,335	886,335	0	0	0	1.00
2.00	91.00	EMERGENCY	1,114,320	0	1,114,320	0	0	2.00
3.00	60.00	LABORATORY	23,477	0	23,477	0	0	3.00
4.00	50.00	OPERATING ROOM	156,275	156,275	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	9,892	9,892	0	0	0	5.00
6.00	90.00	CLINIC	702,182	702,182	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,892,481	1,754,684	1,137,797		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	886,335		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	156,275		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	9,892		5.00
6.00	90.00	CLINIC	0	0	0	702,182		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,754,684		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2019 10:19 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					181	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					23.90	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,327.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.59	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.80	41.80	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					110,966	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)					110,966	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)					110,966	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					110,966	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)					7,566	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)					7,566	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)					4,326	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,892	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)					11,892	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: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2019 10:19 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.59	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						110,966	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						11,892	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)						122,858	63.00
64.00	Total cost of outside supplier services (from your records)						83,123	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						7,566	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						4,326	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						11,892	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						4,326	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						4,326	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2019 10:19 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	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					22.66	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	15.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.23	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.62	39.62	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,228	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)					1,228	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)					1,228	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)					79.23	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					13,073	22.00
23.00	Total salary equivalency (see instructions)					13,073	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)					436	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)					436	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)					249	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					685	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)					685	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2019 10:19 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.23	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
							1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						13,073
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						685
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0
60.00	Overtime allowance (from column 5, line 56)						0
61.00	Equipment cost (see instructions)						0
62.00	Supplies (see instructions)						0
63.00	Total allowance (sum of lines 57-62)						13,758
64.00	Total cost of outside supplier services (from your records)						853
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						436
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						249
100.02	Line 33 = line 28 = sum of lines 26 and 27						685
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						249
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						249
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
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
102.02	Line 35 = sum of lines 31 and 32						0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,068,393	1,068,393			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	469,407		469,407		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,050,579	0	0	3,050,579	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,120,617	277,553	123,247	455,122	3,976,539
6.00	00600	MAINTENANCE & REPAIRS	369,543	0	0	62,546	432,089
7.00	00700	OPERATION OF PLANT	257,209	95,265	42,302	0	394,776
8.00	00800	LAUNDRY & LINEN SERVICE	68,357	36,295	16,117	5,101	125,870
9.00	00900	HOUSEKEEPING	380,919	20,701	9,192	109,559	520,371
10.00	01000	DIETARY	349,877	56,403	25,045	80,949	512,274
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	488,416	10,544	4,682	153,845	657,487
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	1,381,322	16,395	7,280	88,872	1,493,869
16.00	01600	MEDICAL RECORDS & LIBRARY	499,619	22,785	10,117	141,457	673,978
17.00	01700	SOCIAL SERVICE	297	2,236	993	98	3,624
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,363,299	167,745	74,486	422,036	2,027,566
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	527,170	76,386	33,919	111,183	748,658
53.00	05300	ANESTHESIOLOGY	201,287	0	0	0	201,287
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,313,184	23,240	10,320	201,675	1,548,419
60.00	06000	LABORATORY	1,210,417	33,866	15,038	158,566	1,417,887
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	452,285	35,343	15,694	134,384	637,706
66.00	06600	PHYSICAL THERAPY	595,554	47,350	21,025	165,442	829,371
67.00	06700	OCCUPATIONAL THERAPY	108,482	8,888	3,946	33,894	155,210
68.00	06800	SPEECH PATHOLOGY	37,261	1,946	864	23,783	63,854
69.00	06900	ELECTROCARDIOLOGY	52,218	1,035	460	13,517	67,230
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,260	0	0	0	291,260
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	CARDIAC REHABILITATION	98,974	9,150	4,063	33,005	145,192
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,824,254	0	0	199,732	2,023,986
88.01	08801	RURAL HEALTH CLINIC II - FHC	731,605	0	0	52,178	783,783
90.00	09000	CLINIC	223,321	37,206	16,521	69,955	347,003
91.00	09100	EMERGENCY	1,890,610	39,580	17,575	242,152	2,189,917
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,425,736	1,019,912	452,886	2,959,051	22,269,206
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,275	0	0	11,275
192.00	19200	PHYSICIANS PRIVATE OFFICES	199,459	37,206	16,521	60,941	314,127
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0
192.02	19202	INDEPENDENT LIVING	270,330	0	0	30,587	300,917
192.03	19203	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	22,895,525	1,068,393	469,407	3,050,579	22,895,525

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,976,539					5.00
6.00	00600	MAINTENANCE & REPAIRS	90,820	522,909				6.00
7.00	00700	OPERATION OF PLANT	82,977	53,959	531,712			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,456	20,558	27,745	200,629		8.00
9.00	00900	HOUSEKEEPING	109,376	11,725	15,824	0	657,296	9.00
10.00	01000	DIETARY	107,674	31,947	43,115	0	48,802	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	138,196	5,972	8,060	0	9,123	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	313,993	9,286	12,533	0	14,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,662	12,905	17,417	0	19,714	16.00
17.00	01700	SOCIAL SERVICE	762	1,266	1,709	0	1,934	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	426,170	95,015	128,230	200,629	145,139	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	157,359	43,266	58,391	0	66,093	50.00
53.00	05300	ANESTHESIOLOGY	42,308	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,459	13,163	17,765	0	20,108	54.00
60.00	06000	LABORATORY	298,023	19,182	25,888	0	29,303	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	134,038	20,019	27,017	0	30,581	65.00
66.00	06600	PHYSICAL THERAPY	174,324	26,819	36,195	0	40,969	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,623	5,034	6,794	0	7,690	67.00
68.00	06800	SPEECH PATHOLOGY	13,421	1,102	1,487	0	1,684	68.00
69.00	06900	ELECTROCARDIOLOGY	14,131	586	791	0	896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,219	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	30,518	5,183	6,994	0	7,917	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	425,418	47,682	0	0	72,839	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	164,742	27,288	0	0	41,686	88.01
90.00	09000	CLINIC	72,936	21,074	28,441	0	32,193	90.00
91.00	09100	EMERGENCY	460,289	22,418	30,256	0	34,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,844,894	495,449	494,652	200,629	625,103	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,370	6,386	8,619	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	66,026	21,074	28,441	0	32,193	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	63,249	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,976,539	522,909	531,712	200,629	657,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	743,812					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	818,838		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	743,812	0	0	224,453	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	59,132	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	107,259	0	54.00
60.00	06000	LABORATORY	0	0	0	84,331	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	71,471	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	87,989	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	18,026	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	12,649	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,189	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	17,553	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	128,786	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	743,812	0	0	818,838	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	743,812	0	0	818,838	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,843,867					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	865,676				16.00
17.00	01700	SOCIAL SERVICE	0	0	9,295			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	41,074	9,295	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,788	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,999	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	229,442	0	0	0	54.00
60.00	06000	LABORATORY	0	179,780	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	38,583	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	51,239	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,762	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,047	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,607	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,329	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,843,867	69,614	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	8,130	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	46,792	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	12,206	0	0	0	88.01
90.00	09000	CLINIC	0	9,988	0	0	0	90.00
91.00	09100	EMERGENCY	0	69,296	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,843,867	865,676	9,295	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,843,867	865,676	9,295	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,041,383	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,160,687	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	253,594	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,261,615	0	54.00
60.00	06000	LABORATORY	0	0	0	2,054,394	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	959,415	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,246,906	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	233,139	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	97,244	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	106,430	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	397,808	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,913,481	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	221,487	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,616,717	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	1,029,705	0	88.01
90.00	09000	CLINIC	0	0	0	511,635	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,935,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	22,040,848	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	28,650	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	461,861	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	364,166	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	22,895,525	0	202.00

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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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
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
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.01	07301	CARDIAC REHABILITATION	73.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	FAMILY MEDICAL CLINIC	192.01
192.02	19202	INDEPENDENT LIVING	192.02
192.03	19203	MEALS ON WHEELS	192.03
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 STATISTICS

Provider CCN: 14-1331

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

Worksheet Non-CMS W

Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	8	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	9	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	10	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	11	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	12	SQUARE FEET	9.00
10.00	DIETARY	13	PATIENT DAYS	10.00
11.00	CAFETERIA	14	GROSS SALARIES	11.00
12.00	MAINTENANCE OF PERSONNEL	15	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	16	NURSING SALARIES	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUIS.	14.00
15.00	PHARMACY	18	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	20	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	21	ASSIGNED TIME	19.00
20.00	NURSING SCHOOL	22	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	23	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	24	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	25	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:19 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
5.00	00500	ADMINISTRATIVE & GENERAL	0	277,553	123,247	400,800	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	95,265	42,302	137,567	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,295	16,117	52,412	8.00
9.00	00900	HOUSEKEEPING	0	20,701	9,192	29,893	9.00
10.00	01000	DIETARY	0	56,403	25,045	81,448	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	10,544	4,682	15,226	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	16,395	7,280	23,675	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,785	10,117	32,902	16.00
17.00	01700	SOCIAL SERVICE	0	2,236	993	3,229	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	167,745	74,486	242,231	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	76,386	33,919	110,305	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,240	10,320	33,560	54.00
60.00	06000	LABORATORY	0	33,866	15,038	48,904	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	35,343	15,694	51,037	65.00
66.00	06600	PHYSICAL THERAPY	0	47,350	21,025	68,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,888	3,946	12,834	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,946	864	2,810	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,035	460	1,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	9,150	4,063	13,213	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	88.01
90.00	09000	CLINIC	0	37,206	16,521	53,727	90.00
91.00	09100	EMERGENCY	0	39,580	17,575	57,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,019,912	452,886	1,472,798	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,275	0	11,275	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	37,206	16,521	53,727	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	192.03
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	1,068,393	469,407	1,537,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	400,800					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,154	9,154				6.00
7.00	00700	OPERATION OF PLANT	8,363	945	146,875			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,667	360	7,664	63,103		8.00
9.00	00900	HOUSEKEEPING	11,024	205	4,371	0	45,493	9.00
10.00	01000	DIETARY	10,853	559	11,910	0	3,378	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	13,929	105	2,226	0	631	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	31,648	163	3,462	0	982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,278	226	4,811	0	1,364	16.00
17.00	01700	SOCIAL SERVICE	77	22	472	0	134	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,954	1,664	35,421	63,103	10,046	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,860	757	16,129	0	4,574	50.00
53.00	05300	ANESTHESIOLOGY	4,264	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,803	230	4,907	0	1,392	54.00
60.00	06000	LABORATORY	30,038	336	7,151	0	2,028	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	13,510	350	7,463	0	2,117	65.00
66.00	06600	PHYSICAL THERAPY	17,570	469	9,998	0	2,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,288	88	1,877	0	532	67.00
68.00	06800	SPEECH PATHOLOGY	1,353	19	411	0	117	68.00
69.00	06900	ELECTROCARDIOLOGY	1,424	10	219	0	62	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,170	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	3,076	91	1,932	0	548	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	42,878	835	0	0	5,041	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	16,604	478	0	0	2,885	88.01
90.00	09000	CLINIC	7,351	369	7,856	0	2,228	90.00
91.00	09100	EMERGENCY	46,395	392	8,358	0	2,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,531	8,673	136,638	63,103	43,265	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	239	112	2,381	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,655	369	7,856	0	2,228	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	6,375	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	400,800	9,154	146,875	63,103	45,493	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	108,148					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	32,117		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,148	0	0	8,805	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,319	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,207	0	54.00
60.00	06000	LABORATORY	0	0	0	3,308	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,803	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,451	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	707	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	496	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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	688	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	5,051	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,148	0	0	32,117	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	108,148	0	0	32,117	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	59,930					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,581				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,934			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,543	3,934			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,720	0			50.00
53.00	05300	ANESTHESIOLOGY	0	619	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,190	0			54.00
60.00	06000	LABORATORY	0	11,131	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	2,389	0			65.00
66.00	06600	PHYSICAL THERAPY	0	3,172	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	481	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	189	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	966	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,807	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,930	4,310	0			73.00
73.01	07301	CARDIAC REHABILITATION	0	503	0			73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,897	0			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	756	0			88.01
90.00	09000	CLINIC	0	618	0			90.00
91.00	09100	EMERGENCY	0	4,290	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,930	53,581	3,934	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0			192.01
192.02	19202	INDEPENDENT LIVING	0	0	0			192.02
192.03	19203	MEALS ON WHEELS	0	0	0			192.03
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)	59,930	53,581	3,934	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				518,849	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				151,664	0	50.00
53.00	05300	ANESTHESIOLOGY				4,883	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				91,289	0	54.00
60.00	06000	LABORATORY				102,896	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				79,669	0	65.00
66.00	06600	PHYSICAL THERAPY				105,871	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				19,807	0	67.00
68.00	06800	SPEECH PATHOLOGY				5,395	0	68.00
69.00	06900	ELECTROCARDIOLOGY				4,458	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				8,977	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				64,240	0	73.00
73.01	07301	CARDIAC REHABILITATION				20,051	0	73.01
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				51,651	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC				20,723	0	88.01
90.00	09000	CLINIC				72,149	0	90.00
91.00	09100	EMERGENCY				124,011	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,446,583	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				14,007	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES				70,835	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC				0	0	192.01
192.02	19202	INDEPENDENT LIVING				6,375	0	192.02
192.03	19203	MEALS ON WHEELS				0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,537,800	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
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
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.01	07301	CARDIAC REHABILITATION	73.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	FAMILY MEDICAL CLINIC	192.01
192.02	19202	INDEPENDENT LIVING	192.02
192.03	19203	MEALS ON WHEELS	192.03
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: 14-1331

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,417					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,600				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,205,276			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,112	20,112	1,373,360	-3,976,539	18,918,986	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	188,737	0	432,089	6.00
7.00	00700	OPERATION OF PLANT	6,903	6,903	0	0	394,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	15,392	0	125,870	8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	330,598	0	520,371	9.00
10.00	01000	DIETARY	4,087	4,087	244,267	0	512,274	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	464,234	0	657,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	268,176	0	1,493,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	426,853	0	673,978	16.00
17.00	01700	SOCIAL SERVICE	162	162	297	0	3,624	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	1,273,513	0	2,027,566	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,535	5,535	335,501	0	748,658	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	201,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	608,564	0	1,548,419	54.00
60.00	06000	LABORATORY	2,454	2,454	478,479	0	1,417,887	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	405,510	0	637,706	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	499,230	0	829,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	102,277	0	155,210	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	71,766	0	63,854	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	40,789	0	67,230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	291,260	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	99,593	0	145,192	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	602,700	0	2,023,986	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	157,451	0	783,783	88.01
90.00	09000	CLINIC	2,696	2,696	211,093	0	347,003	90.00
91.00	09100	EMERGENCY	2,868	2,868	730,706	0	2,189,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,904	73,904	8,929,086	-3,976,539	18,292,667	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	0	0	0	11,275	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,696	2,696	183,892	0	314,127	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	92,298	0	300,917	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,068,393	469,407	3,050,579		3,976,539	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.800496	6.128029	0.331395		0.210188	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		400,800	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.021185	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: 14-1331

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,896					6.00
7.00	00700	OPERATION OF PLANT	6,903	50,402				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	2,450			8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	0	55,046		9.00
10.00	01000	DIETARY	4,087	4,087	0	4,087	2,450	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	0	764	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	0	1,188	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	0	1,651	0	16.00
17.00	01700	SOCIAL SERVICE	162	162	0	162	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	2,450	12,155	2,450	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,535	5,535	0	5,535	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	0	1,684	0	54.00
60.00	06000	LABORATORY	2,454	2,454	0	2,454	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	0	2,561	0	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	0	3,431	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	0	644	0	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	0	141	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	0	75	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	0	663	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,100	0	0	6,100	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	3,491	0	0	3,491	0	88.01
90.00	09000	CLINIC	2,696	2,696	0	2,696	0	90.00
91.00	09100	EMERGENCY	2,868	2,868	0	2,868	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,383	46,889	2,450	52,350	2,450	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	817	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,696	2,696	0	2,696	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	522,909	531,712	200,629	657,296	743,812	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.816745	10.549423	81.889388	11.940849	303.596735	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,154	146,875	63,103	45,493	108,148	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.136839	2.914071	25.756327	0.826454	44.142041	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: 14-1331

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

Worksheet B-1

Date/Time Prepared:

11/25/2019 10:19 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,645,928			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	1,122,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,273,513	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	335,501	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	608,564	0	0	54.00
60.00	06000	LABORATORY	0	0	478,479	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	405,510	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	499,230	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	102,277	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	71,766	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	40,789	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,122,465	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	99,593	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	730,706	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,645,928	0	1,122,465	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	0	0	818,838	0	1,843,867	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.176249	0.000000	1.642694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	32,117	0	59,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.006913	0.000000	0.053391	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: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,114,153					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,093,061	100	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,416,014	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	509,523	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,692,870	0	0	0	0	54.00
60.00	06000	LABORATORY	9,161,235	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,966,098	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,611,057	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	395,541	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	155,277	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	795,327	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,309,881	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,547,408	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	414,291	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,384,429	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	621,971	0	0	0	0	88.01
90.00	09000	CLINIC	508,963	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,531,207	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,114,153	100	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	865,676	9,295	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019624	92.950000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,581	3,934	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001215	39.340000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	88.01
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	192.03
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	4,041,383		4,041,383	0		0	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,160,687		1,160,687	0		0	50.00
53.00	05300	ANESTHESIOLOGY	253,594		253,594	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,615		2,261,615	0		0	54.00
60.00	06000	LABORATORY	2,054,394		2,054,394	0		0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0		0	62.30
65.00	06500	RESPIRATORY THERAPY	959,415	0	959,415	0		0	65.00
66.00	06600	PHYSICAL THERAPY	1,246,906	0	1,246,906	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,139	0	233,139	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	97,244	0	97,244	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	106,430		106,430	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	397,808		397,808	0		0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,913,481		1,913,481	0		0	73.00
73.01	07301	CARDIAC REHABILITATION	221,487		221,487	0		0	73.01
76.97	07697	CARDIAC REHABILITATION	0		0	0		0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0		0	76.98
76.99	07699	LITHOTRIPSY	0		0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,616,717		2,616,717	0		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,029,705		1,029,705	0		0	88.01
90.00	09000	CLINIC	511,635		511,635	0		0	90.00
91.00	09100	EMERGENCY	2,935,208		2,935,208	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	601,515		601,515			0	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	22,642,363	0	22,642,363	0		0	200.00
201.00		Less Observation Beds	601,515		601,515			0	201.00
202.00		Total (see instructions)	22,040,848	0	22,040,848	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 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	1,286,054		1,286,054		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,182	1,390,832	1,416,014	0.819686	50.00
53.00	05300	ANESTHESIOLOGY	16,974	492,549	509,523	0.497709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,836	11,126,034	11,692,870	0.193418	54.00
60.00	06000	LABORATORY	878,767	8,282,468	9,161,235	0.224249	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	772,100	1,193,998	1,966,098	0.487979	65.00
66.00	06600	PHYSICAL THERAPY	277,559	2,333,498	2,611,057	0.477548	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,625	247,916	395,541	0.589418	67.00
68.00	06800	SPEECH PATHOLOGY	3,384	151,893	155,277	0.626261	68.00
69.00	06900	ELECTROCARDIOLOGY	28,889	766,438	795,327	0.133819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	751,094	1,558,787	2,309,881	0.172220	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,163,507	2,383,901	3,547,408	0.539403	73.00
73.01	07301	CARDIAC REHABILITATION	0	414,291	414,291	0.534617	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,384,429	2,384,429		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	621,971	621,971		88.01
90.00	09000	CLINIC	0	508,963	508,963	1.005250	90.00
91.00	09100	EMERGENCY	28,727	3,502,480	3,531,207	0.831219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,110	805,897	807,007	0.745365	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,947,808	38,166,345	44,114,153		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,947,808	38,166,345	44,114,153		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 CARDIAC REHABILITATION	0.000000			73.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC				88.01
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

				Title XIX		Hospital	PPS	
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	4,041,383		4,041,383	0	4,041,383	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,160,687		1,160,687	0	1,160,687	50.00
53.00	05300	ANESTHESIOLOGY	253,594		253,594	0	253,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,615		2,261,615	0	2,261,615	54.00
60.00	06000	LABORATORY	2,054,394		2,054,394	0	2,054,394	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	959,415	0	959,415	0	959,415	65.00
66.00	06600	PHYSICAL THERAPY	1,246,906	0	1,246,906	0	1,246,906	66.00
67.00	06700	OCCUPATIONAL THERAPY	233,139	0	233,139	0	233,139	67.00
68.00	06800	SPEECH PATHOLOGY	97,244	0	97,244	0	97,244	68.00
69.00	06900	ELECTROCARDIOLOGY	106,430		106,430	0	106,430	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	397,808		397,808	0	397,808	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,913,481		1,913,481	0	1,913,481	73.00
73.01	07301	CARDIAC REHABILITATION	221,487		221,487	0	221,487	73.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,616,717		2,616,717	0	2,616,717	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,029,705		1,029,705	0	1,029,705	88.01
90.00	09000	CLINIC	511,635		511,635	0	511,635	90.00
91.00	09100	EMERGENCY	2,935,208		2,935,208	0	2,935,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	601,515		601,515		601,515	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,642,363	0	22,642,363	0	22,642,363	200.00
201.00		Less Observation Beds	601,515		601,515		601,515	201.00
202.00		Total (see instructions)	22,040,848	0	22,040,848	0	22,040,848	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

			Title XIX			Hospital	PPS	
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	1,286,054		1,286,054			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,182	1,390,832	1,416,014	0.819686	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	16,974	492,549	509,523	0.497709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,836	11,126,034	11,692,870	0.193418	0.000000	54.00
60.00	06000	LABORATORY	878,767	8,282,468	9,161,235	0.224249	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	772,100	1,193,998	1,966,098	0.487979	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,559	2,333,498	2,611,057	0.477548	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,625	247,916	395,541	0.589418	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,384	151,893	155,277	0.626261	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	28,889	766,438	795,327	0.133819	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	751,094	1,558,787	2,309,881	0.172220	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,163,507	2,383,901	3,547,408	0.539403	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	414,291	414,291	0.534617	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,384,429	2,384,429	1.097419	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	621,971	621,971	1.655551	0.000000	88.01
90.00	09000	CLINIC	0	508,963	508,963	1.005250	0.000000	90.00
91.00	09100	EMERGENCY	28,727	3,502,480	3,531,207	0.831219	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,110	805,897	807,007	0.745365	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,947,808	38,166,345	44,114,153			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,947,808	38,166,345	44,114,153			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.819686			50.00
53.00	05300 ANESTHESIOLOGY	0.497709			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193418			54.00
60.00	06000 LABORATORY	0.224249			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.487979			65.00
66.00	06600 PHYSICAL THERAPY	0.477548			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.589418			67.00
68.00	06800 SPEECH PATHOLOGY	0.626261			68.00
69.00	06900 ELECTROCARDIOLOGY	0.133819			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.172220			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.539403			73.00
73.01	07301 CARDIAC REHABILITATION	0.534617			73.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.097419			88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	1.655551			88.01
90.00	09000 CLINIC	1.005250			90.00
91.00	09100 EMERGENCY	0.831219			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.745365			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,160,687	151,664	1,009,023	0	0
53.00	05300	ANESTHESIOLOGY	253,594	4,883	248,711	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,615	91,289	2,170,326	0	0
60.00	06000	LABORATORY	2,054,394	102,896	1,951,498	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	959,415	79,669	879,746	0	0
66.00	06600	PHYSICAL THERAPY	1,246,906	105,871	1,141,035	0	0
67.00	06700	OCCUPATIONAL THERAPY	233,139	19,807	213,332	0	0
68.00	06800	SPEECH PATHOLOGY	97,244	5,395	91,849	0	0
69.00	06900	ELECTROCARDIOLOGY	106,430	4,458	101,972	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	397,808	8,977	388,831	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,913,481	64,240	1,849,241	0	0
73.01	07301	CARDIAC REHABILITATION	221,487	20,051	201,436	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,616,717	51,651	2,565,066	0	0
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,029,705	20,723	1,008,982	0	0
90.00	09000	CLINIC	511,635	72,149	439,486	0	0
91.00	09100	EMERGENCY	2,935,208	124,011	2,811,197	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	601,515	77,225	524,290	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,600,980	1,004,959	17,596,021	0	0
201.00		Less Observation Beds	601,515	77,225	524,290	0	0
202.00		Total (line 200 minus line 201)	17,999,465	927,734	17,071,731	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/25/2019 10:19 pm

				Title XIX		Hospital	PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)			
			6.00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,160,687	1,416,014	0.819686			50.00
53.00	05300	ANESTHESIOLOGY	253,594	509,523	0.497709			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,615	11,692,870	0.193418			54.00
60.00	06000	LABORATORY	2,054,394	9,161,235	0.224249			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	959,415	1,966,098	0.487979			65.00
66.00	06600	PHYSICAL THERAPY	1,246,906	2,611,057	0.477548			66.00
67.00	06700	OCCUPATIONAL THERAPY	233,139	395,541	0.589418			67.00
68.00	06800	SPEECH PATHOLOGY	97,244	155,277	0.626261			68.00
69.00	06900	ELECTROCARDIOLOGY	106,430	795,327	0.133819			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	397,808	2,309,881	0.172220			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,913,481	3,547,408	0.539403			73.00
73.01	07301	CARDIAC REHABILITATION	221,487	414,291	0.534617			73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000			76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000			76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,616,717	2,384,429	1.097419			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,029,705	621,971	1.655551			88.01
90.00	09000	CLINIC	511,635	508,963	1.005250			90.00
91.00	09100	EMERGENCY	2,935,208	3,531,207	0.831219			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	601,515	807,007	0.745365			92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,600,980	42,828,099				200.00
201.00		Less Observation Beds	601,515	0				201.00
202.00		Total (line 200 minus line 201)	17,999,465	42,828,099				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/25/2019 10:19 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	151,664	1,416,014	0.107106	16,149	1,730	50.00
53.00	05300	ANESTHESIOLOGY	4,883	509,523	0.009583	11,070	106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,289	11,692,870	0.007807	377,519	2,947	54.00
60.00	06000	LABORATORY	102,896	9,161,235	0.011232	419,052	4,707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	79,669	1,966,098	0.040521	390,166	15,810	65.00
66.00	06600	PHYSICAL THERAPY	105,871	2,611,057	0.040547	19,099	774	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,807	395,541	0.050076	3,768	189	67.00
68.00	06800	SPEECH PATHOLOGY	5,395	155,277	0.034744	1,854	64	68.00
69.00	06900	ELECTROCARDIOLOGY	4,458	795,327	0.005605	16,680	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,977	2,309,881	0.003886	348,788	1,355	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,240	3,547,408	0.018109	393,385	7,124	73.00
73.01	07301	CARDIAC REHABILITATION	20,051	414,291	0.048398	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	51,651	2,384,429	0.021662	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	20,723	621,971	0.033318	0	0	88.01
90.00	09000	CLINIC	72,149	508,963	0.141757	0	0	90.00
91.00	09100	EMERGENCY	124,011	3,531,207	0.035119	8,687	305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	77,225	807,007	0.095693	0	0	92.00
200.00		Total (lines 50 through 199)	1,004,959	42,828,099		2,006,217	35,204	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:19 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION		0	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC		0	0	0	0	0	88.01
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:19 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,416,014	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	509,523	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,692,870	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,161,235	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,966,098	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,611,057	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	395,541	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	155,277	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	795,327	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,309,881	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,547,408	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	414,291	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,384,429	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	621,971	0.000000	88.01
90.00	09000	CLINIC	0	0	0	508,963	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,531,207	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	807,007	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	42,828,099		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:19 pm

			Title XVIII			Hospital		Cost	
Cost Center Description			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	16,149		0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,070		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	377,519		0	0	0	54.00
60.00	06000	LABORATORY	0.000000	419,052		0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	390,166		0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,099		0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,768		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,854		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,680		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	348,788		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	393,385		0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0		0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0		0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0		0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0		0	0	0	88.01
90.00	09000	CLINIC	0.000000	0		0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	8,687		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0	0	0	92.00
200.00		Total (lines 50 through 199)		2,006,217		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:19 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
60.00	06000	LABORATORY	0	0					
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
73.01	07301	CARDIAC REHABILITATION	0	0					
76.97	07697	CARDIAC REHABILITATION	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
76.99	07699	LITHOTRIPSY	0	0					
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0					
90.00	09000	CLINIC	0	0					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					
200.00		Total (lines 50 through 199)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/25/2019 10:19 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		0.819686	0	505,132	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.497709	0	154,242	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.193418	0	4,205,812	0	0	54.00
60.00	06000	LABORATORY		0.224249	0	3,427,715	215	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.487979	0	409,209	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.477548	0	918,855	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.589418	0	63,374	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.626261	0	17,465	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.133819	0	343,057	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.172220	0	673,283	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.539403	0	1,636,262	0	0	73.00
73.01	07301	CARDIAC REHABILITATION		0.534617	0	269,648	0	0	73.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC		0.000000				0	88.01
90.00	09000	CLINIC		1.005250	0	902	0	0	90.00
91.00	09100	EMERGENCY		0.831219	0	1,025,477	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.745365	0	386,048	0	0	92.00
200.00		Subtotal (see instructions)			0	14,036,481	215	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			0	14,036,481	215	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/25/2019 10:19 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	414,050	0		50.00
53.00	05300	ANESTHESIOLOGY	76,768	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813,480	0		54.00
60.00	06000	LABORATORY	768,662	48		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	199,685	0		65.00
66.00	06600	PHYSICAL THERAPY	438,797	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	37,354	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,938	0		68.00
69.00	06900	ELECTROCARDIOLOGY	45,908	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,953	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	882,605	0		73.00
73.01	07301	CARDIAC REHABILITATION	144,158	0		73.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0		88.01
90.00	09000	CLINIC	907	0		90.00
91.00	09100	EMERGENCY	852,396	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	287,747	0		92.00
200.00		Subtotal (see instructions)	5,089,408	48		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,089,408	48		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331

Period:

Worksheet D

Component CCN: 14-Z331

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/25/2019 10:19 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	0.819686	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.497709	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193418	0	0	0	0	54.00
60.00	06000	LABORATORY	0.224249	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.487979	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.477548	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.589418	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.626261	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133819	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.172220	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.539403	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.534617	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000				0	88.01
90.00	09000	CLINIC	1.005250	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.831219	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.745365	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331

Period:

Worksheet D

Component CCN: 14-Z331

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/25/2019 10:19 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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	CARDIAC REHABILITATION	0	0		73.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		518,849	244,575	274,274	1,204	227.80	30.00
200.00	Total (lines 30 through 199)		518,849		274,274	1,204		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		10	2,278				
200.00	Total (lines 30 through 199)		10	2,278				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	151,664	1,416,014	0.107106	0	50.00
53.00	05300	ANESTHESIOLOGY	4,883	509,523	0.009583	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,289	11,692,870	0.007807	0	54.00
60.00	06000	LABORATORY	102,896	9,161,235	0.011232	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	79,669	1,966,098	0.040521	0	65.00
66.00	06600	PHYSICAL THERAPY	105,871	2,611,057	0.040547	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,807	395,541	0.050076	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,395	155,277	0.034744	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,458	795,327	0.005605	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,977	2,309,881	0.003886	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,240	3,547,408	0.018109	0	73.00
73.01	07301	CARDIAC REHABILITATION	20,051	414,291	0.048398	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	51,651	2,384,429	0.021662	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	20,723	621,971	0.033318	0	88.01
90.00	09000	CLINIC	72,149	508,963	0.141757	0	90.00
91.00	09100	EMERGENCY	124,011	3,531,207	0.035119	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	77,225	807,007	0.095693	0	92.00
200.00		Total (lines 50 through 199)	1,004,959	42,828,099		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/25/2019 10:19 pm	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	1,204	0.00	10	30.00		
200.00		Total (lines 30 through 199)		0	1,204		10	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00					
200.00		Total (lines 30 through 199)	0	0	200.00					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:19 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:19 pm

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,416,014	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	509,523	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,692,870	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,161,235	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,966,098	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,611,057	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	395,541	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	155,277	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	795,327	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,309,881	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,547,408	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	414,291	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,384,429	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	621,971	0.000000	88.01
90.00	09000	CLINIC	0	0	0	508,963	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,531,207	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	807,007	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	42,828,099		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1331		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:19 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
60.00	06000	LABORATORY	0	0					
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
73.01	07301	CARDIAC REHABILITATION	0	0					
76.97	07697	CARDIAC REHABILITATION	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
76.99	07699	LITHOTRIPSY	0	0					
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0					
90.00	09000	CLINIC	0	0					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					
200.00		Total (lines 50 through 199)	0	0					

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:19 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,204	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)	865	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	445	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)	613	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	122	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)	66	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	677	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)	342	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)	549	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	147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,041,383	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)	17,997	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)	9,736	25.00
26.00	Total swing-bed cost (see instructions)	1,905,027	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,136,356	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)	2,136,356	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)	1,774.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,201,255	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)	1,201,255	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:19 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)					670,348 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,871,603 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)					606,838 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					974,135 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,580,973 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)					339 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,774.38 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					601,515 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:19 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	518,849	4,041,383	0.128384	601,515	77,225
91.00	Nursing School cost	0	4,041,383	0.000000	601,515	0
92.00	Allied health cost	0	4,041,383	0.000000	601,515	0
93.00	All other Medical Education	0	4,041,383	0.000000	601,515	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:19 pm
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,204	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)		865	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		530	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)		528	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		84	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)		104	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		10	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)		0	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)		0	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		147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,041,383	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)		12,392	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		15,342	25.00
26.00	Total swing-bed cost (see instructions)		1,905,028	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,136,355	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)		2,136,355	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)		1,774.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,744	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)		17,744	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:19 pm
			Title XIX	Hospital	PPS
Cost Center Description	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)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,744 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)					2,278 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)					2,278 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,466 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)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 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)					339 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,774.38 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					601,515 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	518,849	4,041,383	0.128384	601,515	77,225
91.00	Nursing School cost	0	4,041,383	0.000000	601,515	0
92.00	Allied health cost	0	4,041,383	0.000000	601,515	0
93.00	All other Medical Education	0	4,041,383	0.000000	601,515	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		627,330		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.819686	16,149	13,237	50.00
53.00	05300 ANESTHESIOLOGY	0.497709	11,070	5,510	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193418	377,519	73,019	54.00
60.00	06000 LABORATORY	0.224249	419,052	93,972	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487979	390,166	190,393	65.00
66.00	06600 PHYSICAL THERAPY	0.477548	19,099	9,121	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.589418	3,768	2,221	67.00
68.00	06800 SPEECH PATHOLOGY	0.626261	1,854	1,161	68.00
69.00	06900 ELECTROCARDIOLOGY	0.133819	16,680	2,232	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.172220	348,788	60,068	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.539403	393,385	212,193	73.00
73.01	07301 CARDIAC REHABILITATION	0.534617	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000 CLINIC	1.005250	0	0	90.00
91.00	09100 EMERGENCY	0.831219	8,687	7,221	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.745365	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,006,217	670,348	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,006,217		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331 Component CCN: 14-Z331	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:19 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	0.819686	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.497709	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193418	14,328	2,771	54.00
60.00	06000 LABORATORY	0.224249	217,020	48,667	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487979	285,743	139,437	65.00
66.00	06600 PHYSICAL THERAPY	0.477548	177,334	84,685	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.589418	99,465	58,626	67.00
68.00	06800 SPEECH PATHOLOGY	0.626261	970	607	68.00
69.00	06900 ELECTROCARDIOLOGY	0.133819	3,000	401	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.172220	265,020	45,642	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.539403	423,411	228,389	73.00
73.01	07301 CARDIAC REHABILITATION	0.534617	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000 CLINIC	1.005250	0	0	90.00
91.00	09100 EMERGENCY	0.831219	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.745365	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,486,291	609,225	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,486,291		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.819686	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.497709	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193418	0	0	54.00
60.00	06000 LABORATORY	0.224249	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487979	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.477548	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.589418	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.626261	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.133819	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.172220	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.539403	0	0	73.00
73.01	07301 CARDIAC REHABILITATION	0.534617	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.097419	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	1.655551	0	0	88.01
90.00	09000 CLINIC	1.005250	0	0	90.00
91.00	09100 EMERGENCY	0.831219	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.745365	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 10:19 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,089,456	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,089,456	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,140,351	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)		46,277	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,144,891	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,949,183	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,949,183	30.00
31.00	Primary payer payments		154	31.00
32.00	Subtotal (line 30 minus line 31)		2,949,029	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)		209,256	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		136,016	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		209,256	36.00
37.00	Subtotal (see instructions)		3,085,045	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,085,045	40.00
40.01	Sequestration adjustment (see instructions)		61,701	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,724,423	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		298,921	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 10:19 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/25/2019 10:19 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,611,337		2,347,323	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	01/28/2019	83,900	01/28/2019	121,100	3.01
3.02		03/08/2019	95,000	03/08/2019	256,000	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		178,900		377,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,790,237		2,724,423	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		298,921	6.01
6.02	SETTLEMENT TO PROGRAM		79,053		0	6.02
7.00	Total Medicare program liability (see instructions)		1,711,184		3,023,344	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		05901		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1331
 Component CCN: 14-Z331

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/25/2019 10:19 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		2,031,277		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	01/28/2019	132,500		0	3.01
3.02		03/08/2019	118,000		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		250,500		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)		2,281,777		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		127,342		0	6.02
7.00	Total Medicare program liability (see instructions)		2,154,435		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		05901		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 10:19 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
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1331

Period:

Worksheet E-2

Component CCN: 14-Z331

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 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)		1,596,783	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)		615,317	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		891	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)		2,212,100	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,212,100	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)		2,212,100	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		13,697	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)		2,198,403	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,198,403	0	19.00
19.01	Sequestration adjustment (see instructions)		43,968	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		2,281,777	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)		-127,342	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: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/25/2019 10:19 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,871,603	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,871,603	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,890,319	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,890,319	19.00
20.00	Deductibles (exclude professional component)		163,772	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,726,547	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,726,547	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30,090	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		19,559	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,090	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,746,106	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,746,106	30.00
30.01	Sequestration adjustment (see instructions)		34,922	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,790,237	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)		-79,053	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

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

Provider CCN: 14-1331

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

Worksheet G

Date/Time Prepared:
11/25/2019 10:19 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	223,163	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	6,836,827	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,154,838	0	0	0	6.00
7.00	Inventory	620,315	0	0	0	7.00
8.00	Prepaid expenses	466,130	0	0	0	8.00
9.00	Other current assets	155,985	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)	6,147,582	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,114	0	0	0	12.00
13.00	Land improvements	1,260,841	0	0	0	13.00
14.00	Accumulated depreciation	-1,025,226	0	0	0	14.00
15.00	Buildings	7,674,169	0	0	0	15.00
16.00	Accumulated depreciation	-4,486,787	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	6,686,367	0	0	0	19.00
20.00	Accumulated depreciation	-5,056,503	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	5,713,663	0	0	0	23.00
24.00	Accumulated depreciation	-4,603,293	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	1,586,972	0	0	0	27.00
28.00	Accumulated depreciation	-1,151,133	0	0	0	28.00
29.00	Minor equipment-nondepreciable	26,625	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,628,809	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,126,830	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,126,830	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,903,221	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	942,231	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,397,570	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	423,488	0	0	0	40.00
41.00	Deferred income	25,487	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,788,776	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,739,891	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	917,861	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,657,752	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,446,528	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	6,456,693	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)	6,456,693	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,903,221	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1331

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

Worksheet G-1

Date/Time Prepared:
11/25/2019 10:19 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		8,357,599		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,900,906				2.00
3.00	Total (sum of line 1 and line 2)		6,456,693		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	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)		6,456,693		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	RELEASED FROM RESTRICTION	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)		6,456,693		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	RESTRICTED CONTRIBUTIONS		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	RELEASED FROM RESTRICTION		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: 14-1331

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2019 10:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	841,084		841,084	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	479,745		479,745	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,320,829		1,320,829	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)	1,320,829		1,320,829	17.00
18.00	Ancillary services	4,630,320	34,700,450	39,330,770	18.00
19.00	Outpatient services	0	1,960,164	1,960,164	19.00
20.00	RURAL HEALTH CLINIC	0	2,384,429	2,384,429	20.00
20.01	RURAL HEALTH CLINIC II - FHC	0	621,971	621,971	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUES	0	494,020	494,020	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,951,149	40,161,034	46,112,183	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,882,589		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,882,589		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1331

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

Worksheet G-3

Date/Time Prepared:
11/25/2019 10:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	46,112,183	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,643,798	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,468,385	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,882,589	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,414,204	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	15,239	6.00
7.00	Income from investments	273,062	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	31,870	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	47,864	14.00
15.00	Revenue from rental of living quarters	315,589	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	100,074	17.00
18.00	Revenue from sale of medical records and abstracts	832	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	15,110	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PROGRAM (NET OF EXPENSES)	335,533	24.00
24.01	OTHER INCOME	389,561	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
25.00	Total other income (sum of lines 6-24)	1,524,734	25.00
26.00	Total (line 5 plus line 25)	-1,889,470	26.00
27.00	LOSS ON SALE OF EQUIPMENT	11,436	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	11,436	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,900,906	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8504

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	589,155	0	589,155	-102,726	486,429
2.00	Physician Assistant	170,925	0	170,925	0	170,925
3.00	Nurse Practitioner	301,308	0	301,308	0	301,308
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	94,510	0	94,510	0	94,510
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,155,898	0	1,155,898	-102,726	1,053,172
11.00	Physician Services Under Agreement	0	160,603	160,603	0	160,603
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	160,603	160,603	0	160,603
15.00	Medical Supplies	0	99,325	99,325	0	99,325
16.00	Transportation (Health Care Staff)	0	17,895	17,895	0	17,895
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	117,220	117,220	0	117,220
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,155,898	277,823	1,433,721	-102,726	1,330,995
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	8,637	8,637	0	8,637
30.00	Administrative Costs	286,422	121,775	408,197	78,245	486,442
31.00	Total Facility Overhead (sum of lines 29 and 30)	286,422	130,412	416,834	78,245	495,079
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,442,320	408,235	1,850,555	-24,481	1,826,074

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8504

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	486,429	1.00
2.00	Physician Assistant	0	170,925	2.00
3.00	Nurse Practitioner	0	301,308	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	94,510	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,053,172	10.00
11.00	Physician Services Under Agreement	0	160,603	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	160,603	14.00
15.00	Medical Supplies	0	99,325	15.00
16.00	Transportation (Health Care Staff)	0	17,895	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	117,220	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,330,995	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	8,637	29.00
30.00	Administrative Costs	-1,820	484,622	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,820	493,259	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,820	1,824,254	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8597

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	42,824	0	42,824	200,542	243,366
2.00	Physician Assistant	119,844	0	119,844	0	119,844
3.00	Nurse Practitioner	72,504	0	72,504	0	72,504
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	96,282	0	96,282	0	96,282
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	23,844	0	23,844	0	23,844
10.00	Subtotal (sum of lines 1 through 9)	355,298	0	355,298	200,542	555,840
11.00	Physician Services Under Agreement	0	0	0	0	0
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	0	0	0	0
15.00	Medical Supplies	0	36,607	36,607	0	36,607
16.00	Transportation (Health Care Staff)	0	938	938	0	938
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	37,545	37,545	0	37,545
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	355,298	37,545	392,843	200,542	593,385
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	20,461	20,461	0	20,461
30.00	Administrative Costs	32,069	45,421	77,490	40,269	117,759
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,069	65,882	97,951	40,269	138,220
32.00	Total facility costs (sum of lines 22, 28 and 31)	387,367	103,427	490,794	240,811	731,605

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8597

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	243,366		1.00
2.00	Physician Assistant	0	119,844		2.00
3.00	Nurse Practitioner	0	72,504		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	96,282		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	23,844		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	555,840		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	36,607		15.00
16.00	Transportation (Health Care Staff)	0	938		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	37,545		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	593,385		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	20,461		29.00
30.00	Administrative Costs	0	117,759		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	138,220		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	731,605		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331

Period:

Worksheet M-2

Component CCN: 14-8504

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 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	0.91	2,879	4,200	3,822		1.00
2.00	Physician Assistant	0.09	2,029	2,100	189		2.00
3.00	Nurse Practitioner	2.18	6,343	2,100	4,578		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.18	11,251		8,589	11,251	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.01	11			11	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.19	11,262			11,262	8.00
9.00	Physician Services Under Agreements		415			415	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,330,995	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,330,995	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)					493,259	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					792,463	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,285,722	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,285,722	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,285,722	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,616,717	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331

Period:

Worksheet M-2

Component CCN: 14-8597

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:19 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.52	1,842	4,200	2,184		1.00
2.00	Physician Assistant	0.71	2,276	2,100	1,491		2.00
3.00	Nurse Practitioner	0.56	505	2,100	1,176		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.79	4,623		4,851	4,851	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.79	4,623			4,851	8.00
9.00	Physician Services Under Agreements		95			95	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)					593,385	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)					593,385	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)					138,220	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					298,100	15.00
16.00	Total overhead (sum of lines 14 and 15)					436,320	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					436,320	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					436,320	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,029,705	20.00

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8504		Date/Time Prepared: 11/25/2019 10:19 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)			2,616,717	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			23,844	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,592,873	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,262	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			415	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11,677	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.05	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		222.05	222.05	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,650	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	810,483	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	810,483	16.00
16.01	Total program charges (see instructions)(from contractor's records)			566,575	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			21	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			30	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.)			611,534	16.04
16.05	Total program cost (see instructions)		0	611,564	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			46,035	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			104,103	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			611,564	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,923	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			614,487	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			614,487	26.00
26.01	Sequestration adjustment (see instructions)			12,290	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			523,261	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)			78,936	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1331	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8597		Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,029,705	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,363	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,026,342	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,851	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			95	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,946	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			207.51	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		207.51	207.51	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	757	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	157,085	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	157,085	16.00
16.01	Total program charges (see instructions)(from contractor's records)			103,990	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			550	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			831	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.)			120,126	16.04
16.05	Total program cost (see instructions)		0	120,957	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,096	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19,469	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			120,957	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			74	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			121,031	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			121,031	26.00
26.01	Sequestration adjustment (see instructions)			2,421	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			34,754	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)			83,856	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: 14-1331 Component CCN: 14-8504	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,053,172	1,053,172	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000169	0.000244	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		178	257	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,135	4,558	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		7,313	4,815	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,330,995	1,330,995	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,285,722	1,285,722	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005494	0.003618	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,064	4,652	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		14,377	9,467	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		78	114	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		184.32	83.04	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		10	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,843	1,080	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)			23,844	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)			2,923	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1331 Component CCN: 14-8597	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 10:19 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		555,840	555,840	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000056	0.000088	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		31	49	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,098	760	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,129	809	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		593,385	593,385	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		436,320	436,320	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001903	0.001363	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		830	595	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,959	1,404	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		12	19	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		163.25	73.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	74	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)			3,363	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)			74	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1331 Component CCN: 14-8504	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 10:19 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			470,561	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			01/28/2019	32,700	3.01
3.02			03/08/2019	20,000	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)			52,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			523,261	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			78,936	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			602,197	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	
			1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1331 Component CCN: 14-8597	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 10:19 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			34,754	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			34,754	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			83,856	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			118,610	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00