

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet S
Parts I-III
Date/Time Prepared:
7/23/2019 10:39 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 7/23/2019	Time: 10:39 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 SARAH D CULBERTSON (14-1333) for the cost reporting period beginning 03/01/2018 and ending 02/28/2019 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) JOHN KESSLER

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	179,280	410,558	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	86,384	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-24,865		0	10.00
200.00	Total	0	265,664	385,693	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: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet S-2 Part I Date/Time Prepared: 7/23/2019 10:39 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 238 SOUTH CONGRESS			PO Box:				1.00				
2.00	City: RUSHVILLE			State: IL		Zip Code: 62681		County: SCHUYLER				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			SARAH D CULBERTSON	141333	99914	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			SDCMH SWING BED- SNF	14Z333	99914		05/01/2004	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			ELMER HUGH TAYLOR CLINIC	143483	99914		10/01/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						03/01/2018		02/28/2019		20.00	
21.00	Type of Control (see instructions)						11				21.00	
							1.00		2.00		3.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N						22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	0	24.00	

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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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 03/01/2018
To 02/28/2019Worksheet S-2
Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
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)				N	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00

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			1.00	2.00	3.00
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
			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.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	99,971		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							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet S-2 Part I Date/Time Prepared: 7/23/2019 10:39 am	
				1.00		2.00			
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
				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.								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.				N				146.00
				1.00					
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N				149.00
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
				1.00		2.00		4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital		N		N		N		155.00
156.00	Subprovider - IPF		N		N		N		156.00
157.00	Subprovider - IRF		N		N		N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF		N		N		N		159.00
160.00	HOME HEALTH AGENCY		N		N		N		160.00
161.00	CMHC				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	
				0		1.00		2.00	
						3.00		4.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
				1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00				169.00
				Beginning		Ending			
				1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2018		12/29/2018		170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet S-2 Part I Date/Time Prepared: 7/23/2019 10:39 am
		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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet S-2 Part II Date/Time Prepared: 7/23/2019 10:39 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N		Legal Oper.	
				1.00		2.00	
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	05/15/2019	Y	05/15/2019 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet S-2
Part II
Date/Time Prepared:
7/23/2019 10:39 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	641-494-2144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet S-2 Part II Date/Time Prepared: 7/23/2019 10:39 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet S-3
Part I
Date/Time Prepared:
7/23/2019 10:39 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	18,304.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	18,304.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,030	18,304.00	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 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet S-3
Part I
Date/Time Prepared:
7/23/2019 10:39 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	551	31	768			1.00
2.00	HMO and other (see instructions)	22	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	453	0	519			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	58			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,004	31	1,345			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)	1,004	31	1,345	0.00	130.18	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	RHC (CONSOLIDATED)	3,895	1,005	15,281	0.00	22.31	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	152.49	27.00
28.00	Observation Bed Days		0	146			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: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet S-3
Part I
Date/Time Prepared:
7/23/2019 10:39 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	150	18	223	1.00
2.00 HMO and other (see instructions)			6	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	150	18	223	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 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1333 Component CCN: 14-3483		Period: From 03/01/2018 To 02/28/2019		Worksheet S-8 Date/Time Prepared: 7/23/2019 10:39 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				238 S. CONGRESS		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				RUSHVILLE		IL 62681		2.00
								1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y		4		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				COMMUNITY MEDICAL CLINIC		143484		14.00
14.01					ELMER HUGH TAYLOR CLINIC		143483		14.01
14.02					RUSHVILLE FAMILY PRACTICE		148578		14.02
14.03					COMMUNITY MEDICAL CLINIC OF TABLE GR		148585		14.03
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				SCHUYLER				2.00

MCRIF32 - 15.6.166.3

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet S-10

Date/Time Prepared:
7/23/2019 10:39 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.642618	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,451,070	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?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,587,691	5.00
6.00	Medicaid charges		6,461,670	6.00
7.00	Medicaid cost (line 1 times line 6)		4,152,385	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)		1,113,624	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)		1,113,624	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)	53,041	11,281	64,322
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	34,085	11,281	45,366
22.00	Payments received from patients for amounts previously written off as charity care	10,738	2,664	13,402
23.00	Cost of charity care (line 21 minus line 22)	23,347	8,617	31,964
				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)		811,540	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		195,054	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		300,084	27.01
28.00	Non-Medicare bad debt expense (see instructions)		511,456	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		433,701	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		465,665	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,579,289	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		511,546	511,546	17,181	528,727	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		128,892	128,892	3,121	132,013	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		27,943	27,943	1,727	29,670	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		422,656	422,656	12,742	435,398	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,950,533	2,950,533	0	2,950,533	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	216,549	82,127	298,676	0	298,676	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	362,840	272,005	634,845	0	634,845	5.04
5.05	00590	OTHER ADMIN. & GENERAL	659,806	1,435,914	2,095,720	-39,285	2,056,435	5.05
6.00	00600	MAINTENANCE & REPAIRS	198,373	70,482	268,855	0	268,855	6.00
7.00	00700	OPERATION OF PLANT	60,031	176,337	236,368	0	236,368	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	32,074	32,074	86,182	118,256	7.01
9.00	00900	HOUSEKEEPING	267,283	25,168	292,451	0	292,451	9.00
10.00	01000	DIETARY	329,688	302,555	632,243	0	632,243	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	102,438	6,387	108,825	0	108,825	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	401,978	53,724	455,702	0	455,702	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	197,455	0	197,455	0	197,455	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	787,251	89,511	876,762	0	876,762	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139,871	346,323	486,194	0	486,194	50.00
53.00	05300	ANESTHESIOLOGY	0	12,410	12,410	0	12,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	485,261	620,181	1,105,442	47,022	1,152,464	54.00
60.00	06000	LABORATORY	517,957	687,842	1,205,799	34,958	1,240,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	27,728	27,728	0	27,728	62.00
65.00	06500	RESPIRATORY THERAPY	28,451	37,925	66,376	0	66,376	65.00
66.00	06600	PHYSICAL THERAPY	273,088	187,224	460,312	-145,421	314,891	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,244	0	124,244	87,130	211,374	67.00
68.00	06800	SPEECH PATHOLOGY	55,749	0	55,749	58,291	114,040	68.00
69.00	06900	ELECTROCARDIOLOGY	96,269	116,112	212,381	0	212,381	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,813	53,813	0	53,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	854,685	854,685	0	854,685	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,326,786	411,103	2,737,889	-168,162	2,569,727	88.00
90.00	09000	CLINIC	209,740	1,626,583	1,836,323	0	1,836,323	90.00
90.02	09002	GEROPSYCH	135,936	102,380	238,316	0	238,316	90.02
91.00	09100	EMERGENCY	416,805	2,255,918	2,672,723	0	2,672,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,393,849	13,928,081	22,321,930	-4,514	22,317,416	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	182,722	103,459	286,181	4,514	290,695	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	19,697	31,516	51,213	0	51,213	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,596,268	14,063,056	22,659,324	0	22,659,324	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	528,727	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	-1,350	130,663	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	29,670	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-9,082	426,316	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	422,088	3,372,621	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-12,285	286,391	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-54,518	580,327	5.04
5.05	00590	OTHER ADMIN. & GENERAL	-81,056	1,975,379	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	268,855	6.00
7.00	00700	OPERATION OF PLANT	-553	235,815	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	118,256	7.01
9.00	00900	HOUSEKEEPING	0	292,451	9.00
10.00	01000	DIETARY	-172,811	459,432	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	108,825	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,042	446,660	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	197,455	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	876,762	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-274,912	211,282	50.00
53.00	05300	ANESTHESIOLOGY	0	12,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,152,464	54.00
60.00	06000	LABORATORY	0	1,240,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	27,728	62.00
65.00	06500	RESPIRATORY THERAPY	0	66,376	65.00
66.00	06600	PHYSICAL THERAPY	0	314,891	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	211,374	67.00
68.00	06800	SPEECH PATHOLOGY	0	114,040	68.00
69.00	06900	ELECTROCARDIOLOGY	-30,420	181,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	854,685	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-15,501	2,554,226	88.00
90.00	09000	CLINIC	-508,064	1,328,259	90.00
90.02	09002	GEROPSYCH	0	238,316	90.02
91.00	09100	EMERGENCY	-274,799	2,397,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,022,305	21,295,111	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	290,695	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	194.01
194.02	07952	FOUNDATION	0	51,213	194.02
194.03	07953	OUTPATIENT MEALS	0	0	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,022,305	21,637,019	200.00

RECLASSIFICATIONS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A-6

Date/Time Prepared:
7/23/2019 10:39 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - PROPERTY INSURANCE					
1.00 OTHER CAP REL COSTS	3.00	0	34,771		1.00
2.00 CULBERTSON GARDENS	194.00	0	4,514		2.00
TOTALS		0	39,285		
C - RHC EXPENSES					
1.00 RADIOLOGY-DIAGNOSTIC	54.00	47,022	0		1.00
2.00 LABORATORY	60.00	34,958	0		2.00
3.00 PLANT & HOUSEKEEPING-RHC	7.01	66,651	19,531		3.00
TOTALS		148,631	19,531		
D - THERAPY RECLASS					
1.00 OCCUPATIONAL THERAPY	67.00	46,126	41,004		1.00
2.00 SPEECH PATHOLOGY	68.00	30,859	27,432		2.00
TOTALS		76,985	68,436		
500.00 Grand Total: Increases		225,616	127,252		500.00

RECLASSIFICATIONS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A-6

Date/Time Prepared:
7/23/2019 10:39 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - PROPERTY INSURANCE						
1.00	OTHER ADMIN. & GENERAL	5.05	0	39,285	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	39,285		
C - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	148,631	19,531	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		148,631	19,531		
D - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	76,985	68,436	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		76,985	68,436		
500.00	Grand Total: Decreases		225,616	127,252		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet A-7
Part I
Date/Time Prepared:
7/23/2019 10:39 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	426,152	0	0	0	0	1.00	
2.00	Land Improvements	1,165,295	0	0	0	0	2.00	
3.00	Buildings and Fixtures	6,313,045	492,732	0	492,732	0	3.00	
4.00	Building Improvements	34,106	0	0	0	34,106	4.00	
5.00	Fixed Equipment	5,834,187	0	0	0	10,902	5.00	
6.00	Movable Equipment	6,536,659	119,731	0	119,731	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	20,309,444	612,463	0	612,463	45,008	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	20,309,444	612,463	0	612,463	45,008	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	426,152	0				1.00	
2.00	Land Improvements	1,165,295	0				2.00	
3.00	Buildings and Fixtures	6,805,777	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	5,823,285	0				5.00	
6.00	Movable Equipment	6,656,390	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	20,876,899	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	20,876,899	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet A-7
Part II
Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	498,250	13,296	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	119,292	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	27,943	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	295,520	127,136	0	0	0	2.00
3.00	Total (sum of lines 1-2)	941,005	150,032	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		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	511,546				1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	128,892				1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	27,943				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	422,656				2.00
3.00	Total (sum of lines 1-2)	0	1,091,037				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet A-7
Part III
Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	8,616,385	0	8,616,385	0.494111	17,181	1.00	
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,565,364	0	1,565,364	0.089767	3,121	1.01	
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	866,056	0	866,056	0.049664	1,727	1.02	
2.00	CAP REL COSTS-MVBLE EQUIP	6,390,353	0	6,390,353	0.366458	12,742	2.00	
3.00	Total (sum of lines 1-2)	17,438,158	0	17,438,158	1.000000	34,771	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	17,181	498,250	13,296	1.00	
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	3,121	117,942	9,600	1.01	
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	1,727	27,943	0	1.02	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	12,742	286,438	127,136	2.00	
3.00	Total (sum of lines 1-2)	0	0	34,771	930,573	150,032	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	17,181	0	0	528,727	1.00	
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	3,121	0	0	130,663	1.01	
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	1,727	0	0	29,670	1.02	
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,742	0	0	426,316	2.00	
3.00	Total (sum of lines 1-2)	0	34,771	0	0	1,115,376	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A-8

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
				Cost Center	Line #			
								1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-26,582		HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-637		OTHER ADMIN. & GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-869		OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-553		OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,083,533				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-172,782		DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,042		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines	B	-29		DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME		0		NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME		0		NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A-8

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A-8-3		0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0NONPHYSICIAN ANESTHETISTS	19.00		28.00	
29.00	Physicians' assistant		0	0.00	0	29.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		0OCCUPATIONAL THERAPY	67.00		30.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-8,175	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	-4,631	OTHER ADMIN. & GENERAL	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-1,566	OTHER ADMIN. & GENERAL	5.05	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.02
33.03	MARKETING SALARY EXPENSE	A	-18,700	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.03
33.04	MARKETING BENEFITS EXPENSE	A	-7,331	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-33,477	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-10,781	OTHER ADMIN. & GENERAL	5.05	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-10,838	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-907	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING PORTION OF DUES	A	-704	OTHER ADMIN. & GENERAL	5.05	0	33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	24,241	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-12,285	HOSPITAL BUSINESS OFFICE	5.02	0	33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,816	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
33.14	PATIENT COLLECTION FEES	B	-61,426	OTHER ADMIN. & GENERAL	5.05	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	PROPERTY TAXES	A	-442	OTHER ADMIN. & GENERAL	5.05	0	33.16
33.17	IMRF CONTRIBUTION	A	434,235	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	OPC RENT - CLINIC	B	-9,325	CLINIC	90.00	0	33.18
33.19	OPC RENT - RHC	B	-1,350	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	9	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,022,305				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: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet A-8-2

Date/Time Prepared:
7/23/2019 10:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	274,912	274,912	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	12,000	0	12,000	0	0	2.00
3.00	60.00	LABORATORY	15,600	0	15,600	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	0	6,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	30,420	30,420	0	0	0	5.00
6.00	90.00	CLINIC	210,000	210,000	0	0	0	6.00
7.00	90.00	CLINIC	244,000	244,000	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	44,739	44,739	0	0	0	9.00
10.00	91.00	EMERGENCY	1,931,975	274,799	1,657,176	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	4,663	4,663	0	0	0	11.00
200.00			2,774,309	1,083,533	1,690,776		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	274,912		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	30,420		5.00
6.00	90.00	CLINIC	0	0	0	210,000		6.00
7.00	90.00	CLINIC	0	0	0	244,000		7.00
8.00	90.00	CLINIC	0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	44,739		9.00
10.00	91.00	EMERGENCY	0	0	0	274,799		10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	4,663		11.00
200.00			0	0	0	1,083,533		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2019 10:39 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						50	1.00
2.00	Line 1 multiplied by 15 hours per week						750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						348	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						0.00	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	1,990.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	103.63	82.90	62.18	38.50	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)	41.45	41.45	31.09			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)						164,971	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)						164,971	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)						164,971	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)						164,971	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)						14,425	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)						14,425	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)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						14,425	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)						14,425	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: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2019 10:39 am		
				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	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	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)	82.90	62.18	38.50	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)						164,971	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						14,425	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)						179,396	63.00
64.00	Total cost of outside supplier services (from your records)						127,462	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						14,425	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						14,425	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						0	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						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet B
Part I
Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME		MVBLE EQUIP
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	528,727	528,727				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	130,663	0	130,663			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	29,670	0	0	29,670		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	426,316				426,316	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,372,621	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	286,391	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	580,327	31,582	0	0	25,465	5.04
5.05	00590	OTHER ADMIN. & GENERAL	1,975,379	45,969	0	0	37,065	5.05
6.00	00600	MAINTENANCE & REPAIRS	268,855	53,072	0	0	42,793	6.00
7.00	00700	OPERATION OF PLANT	235,815	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	118,256	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	292,451	19,239	0	0	15,512	9.00
10.00	01000	DIETARY	459,432	26,163	0	0	21,095	10.00
11.00	01100	CAFETERIA	0	8,938	0	0	7,207	11.00
13.00	01300	NURSING ADMINISTRATION	108,825	1,135	0	0	915	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	446,660	22,918	0	0	18,479	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	197,455	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	876,762	56,610	0	0	45,645	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	211,282	40,000	0	0	32,253	50.00
53.00	05300	ANESTHESIOLOGY	12,410	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,152,464	29,832	0	0	24,054	54.00
60.00	06000	LABORATORY	1,240,757	11,294	0	0	9,106	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,728	946	0	0	763	62.00
65.00	06500	RESPIRATORY THERAPY	66,376	7,151	0	0	5,766	65.00
66.00	06600	PHYSICAL THERAPY	314,891	17,196	0	0	13,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	211,374	8,721	0	0	7,032	67.00
68.00	06800	SPEECH PATHOLOGY	114,040	4,417	0	0	3,562	68.00
69.00	06900	ELECTROCARDIOLOGY	181,961	1,022	0	0	824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,813	14,670	0	0	11,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	854,685	6,536	0	0	5,270	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,554,226	0	130,663	29,670	0	88.00
90.00	09000	CLINIC	1,328,259	73,673	0	0	59,401	90.00
90.02	09002	GEROPSYCH	238,316	25,831	0	0	20,828	90.02
91.00	09100	EMERGENCY	2,397,924	21,812	0	0	17,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,295,111	528,727	130,663	29,670	426,316	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	290,695	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	51,213	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	21,637,019	528,727	130,663	29,670	426,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet B
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,372,621					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	80,430	366,821				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	135,507	0	772,881	772,881		5.04
5.05	00590	OTHER ADMIN. & GENERAL	259,802	0	2,318,215	87,647	2,405,862	5.05
6.00	00600	MAINTENANCE & REPAIRS	78,110	0	442,830	16,743	459,573	6.00
7.00	00700	OPERATION OF PLANT	23,638	0	259,453	9,809	269,262	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	26,244	0	144,500	5,463	149,963	7.01
9.00	00900	HOUSEKEEPING	105,244	0	432,446	16,350	448,796	9.00
10.00	01000	DIETARY	129,816	0	636,506	24,065	660,571	10.00
11.00	01100	CAFETERIA	0	0	16,145	610	16,755	11.00
13.00	01300	NURSING ADMINISTRATION	40,335	0	151,210	5,717	156,927	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,281	0	646,338	24,437	670,775	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	77,749	0	275,204	10,405	285,609	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	309,984	20,359	1,309,360	49,504	1,358,864	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	55,075	11,113	349,723	13,222	362,945	50.00
53.00	05300	ANESTHESIOLOGY	0	4,096	16,506	624	17,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,589	95,447	1,511,386	57,142	1,568,528	54.00
60.00	06000	LABORATORY	217,713	74,779	1,553,649	58,740	1,612,389	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	912	30,349	1,147	31,496	62.00
65.00	06500	RESPIRATORY THERAPY	11,203	1,942	92,438	3,495	95,933	65.00
66.00	06600	PHYSICAL THERAPY	77,217	13,443	436,612	16,507	453,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,084	5,228	299,439	11,321	310,760	67.00
68.00	06800	SPEECH PATHOLOGY	34,102	3,498	159,619	6,035	165,654	68.00
69.00	06900	ELECTROCARDIOLOGY	37,906	20,348	242,061	9,152	251,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,638	83,950	3,174	87,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,672	887,163	33,542	920,705	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	857,658	27,186	3,599,403	136,079	3,735,482	88.00
90.00	09000	CLINIC	82,586	38,229	1,582,148	59,818	1,641,966	90.00
90.02	09002	GEROPSYCH	53,525	1,018	339,518	12,836	352,354	90.02
91.00	09100	EMERGENCY	164,119	24,913	2,626,355	99,297	2,725,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,292,917	366,821	21,215,407	772,881	21,215,407	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	71,948	0	362,643	0	362,643	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	7,756	0	58,969	0	58,969	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	3,372,621	366,821	21,637,019	772,881	21,637,019	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
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Cost Center Description			OTHER ADMIN. & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING- RHC	HOUSEKEEPING	
			5.05	6.00	7.00	7.01	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,405,862					5.05
6.00	00600	MAINTENANCE & REPAIRS	57,494	517,067				6.00
7.00	00700	OPERATION OF PLANT	33,685	0	302,947			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	18,761	0	0	168,724		7.01
9.00	00900	HOUSEKEEPING	56,145	24,988	14,640	0	544,569	9.00
10.00	01000	DIETARY	82,639	33,981	19,909	0	37,605	10.00
11.00	01100	CAFETERIA	2,096	11,609	6,802	0	12,848	11.00
13.00	01300	NURSING ADMINISTRATION	19,632	1,474	864	0	1,631	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,915	29,767	17,440	0	32,942	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	35,730	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	169,997	73,526	43,079	0	81,369	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,405	51,954	30,439	0	57,496	50.00
53.00	05300	ANESTHESIOLOGY	2,143	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,226	38,747	22,702	0	42,880	54.00
60.00	06000	LABORATORY	201,713	14,668	8,594	0	16,233	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,940	1,229	720	0	1,360	62.00
65.00	06500	RESPIRATORY THERAPY	12,001	9,288	5,442	0	10,278	65.00
66.00	06600	PHYSICAL THERAPY	56,686	22,334	13,086	0	24,717	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,877	11,327	6,636	0	12,535	67.00
68.00	06800	SPEECH PATHOLOGY	20,724	5,737	3,361	0	6,349	68.00
69.00	06900	ELECTROCARDIOLOGY	31,427	1,327	777	0	1,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,899	19,054	11,164	0	21,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,182	8,489	4,974	0	9,395	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	467,323	0	0	168,724	0	88.00
90.00	09000	CLINIC	205,413	95,688	56,063	0	105,896	90.00
90.02	09002	GEROPSYCH	44,080	33,551	19,657	0	37,129	90.02
91.00	09100	EMERGENCY	340,985	28,329	16,598	0	31,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,353,118	517,067	302,947	168,724	544,569	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	45,367	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	7,377	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	2,405,862	517,067	302,947	168,724	544,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	834,705					10.00
11.00	01100	CAFETERIA	437,090	487,200				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,850	188,378			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,695	0	899,534		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	321,339	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	104,860	111,751	89,218	108,787	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,339	12,243	25,024	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,444	0	0	321,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,830	0	55,315	0	54.00
60.00	06000	LABORATORY	0	64,695	0	42,145	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,158	2,521	9,746	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,160	0	47,940	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,016	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,557	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,730	9,358	20,282	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	191,233	0	88.00
90.00	09000	CLINIC	0	25,219	20,123	173,585	0	90.00
90.02	09002	GEROPSYCH	0	16,783	13,418	0	0	90.02
91.00	09100	EMERGENCY	0	51,973	41,497	225,477	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	541,950	487,200	188,378	899,534	321,339	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	269,858	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	22,897	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	834,705	487,200	188,378	899,534	321,339	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL				5.04
5.05	00590	OTHER ADMIN. & GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC				7.01
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,141,451	0	2,141,451	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	600,845	0	600,845	50.00
53.00	05300	ANESTHESIOLOGY	348,056	0	348,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,983,228	0	1,983,228	54.00
60.00	06000	LABORATORY	1,960,437	0	1,960,437	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,745	0	38,745	62.00
65.00	06500	RESPIRATORY THERAPY	148,367	0	148,367	65.00
66.00	06600	PHYSICAL THERAPY	651,042	0	651,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,151	0	390,151	67.00
68.00	06800	SPEECH PATHOLOGY	206,382	0	206,382	68.00
69.00	06900	ELECTROCARDIOLOGY	327,582	0	327,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,328	0	149,328	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,058,745	0	1,058,745	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,562,762	0	4,562,762	88.00
90.00	09000	CLINIC	2,323,953	0	2,323,953	90.00
90.02	09002	GEROPSYCH	516,972	0	516,972	90.02
91.00	09100	EMERGENCY	3,461,862	0	3,461,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,869,908	0	20,869,908	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	677,868	0	677,868	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	194.01
194.02	07952	FOUNDATION	66,346	0	66,346	194.02
194.03	07953	OUTPATIENT MEALS	22,897	0	22,897	194.03
194.04	07954	VACANT SPACE	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,637,019	0	21,637,019	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1333

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	31,582	0	0	25,465	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	45,969	0	0	37,065	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	53,072	0	0	42,793	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	0	19,239	0	0	15,512	9.00
10.00	01000	DIETARY	0	26,163	0	0	21,095	10.00
11.00	01100	CAFETERIA	0	8,938	0	0	7,207	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,135	0	0	915	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,918	0	0	18,479	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	56,610	0	0	45,645	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	40,000	0	0	32,253	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,832	0	0	24,054	54.00
60.00	06000	LABORATORY	0	11,294	0	0	9,106	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	946	0	0	763	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,151	0	0	5,766	65.00
66.00	06600	PHYSICAL THERAPY	0	17,196	0	0	13,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,721	0	0	7,032	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,417	0	0	3,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,022	0	0	824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,670	0	0	11,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,536	0	0	5,270	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	130,663	29,670	0	88.00
90.00	09000	CLINIC	0	73,673	0	0	59,401	90.00
90.02	09002	GEROPSYCH	0	25,831	0	0	20,828	90.02
91.00	09100	EMERGENCY	0	21,812	0	0	17,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	528,727	130,663	29,670	426,316	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	528,727	130,663	29,670	426,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMIN. & GENERAL	
			2A	4.00	5.02	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	57,047	0	0	57,047		5.04
5.05	00590	OTHER ADMIN. & GENERAL	83,034	0	0	6,470	89,504	5.05
6.00	00600	MAINTENANCE & REPAIRS	95,865	0	0	1,236	2,139	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	724	1,253	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	403	698	7.01
9.00	00900	HOUSEKEEPING	34,751	0	0	1,207	2,089	9.00
10.00	01000	DIETARY	47,258	0	0	1,776	3,074	10.00
11.00	01100	CAFETERIA	16,145	0	0	45	78	11.00
13.00	01300	NURSING ADMINISTRATION	2,050	0	0	422	730	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,397	0	0	1,804	3,122	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	768	1,329	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	102,255	0	0	3,654	6,324	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,253	0	0	976	1,689	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	46	80	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,886	0	0	4,218	7,300	54.00
60.00	06000	LABORATORY	20,400	0	0	4,336	7,504	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,709	0	0	85	147	62.00
65.00	06500	RESPIRATORY THERAPY	12,917	0	0	258	446	65.00
66.00	06600	PHYSICAL THERAPY	31,061	0	0	1,219	2,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,753	0	0	836	1,446	67.00
68.00	06800	SPEECH PATHOLOGY	7,979	0	0	445	771	68.00
69.00	06900	ELECTROCARDIOLOGY	1,846	0	0	676	1,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,499	0	0	234	405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,806	0	0	2,476	4,285	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	160,333	0	0	10,039	17,388	88.00
90.00	09000	CLINIC	133,074	0	0	4,416	7,642	90.00
90.02	09002	GEROPSYCH	46,659	0	0	948	1,640	90.02
91.00	09100	EMERGENCY	39,399	0	0	7,330	12,685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,115,376	0	0	57,047	87,542	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	1,688	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	274	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,115,376	0	0	57,047	89,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING- RHC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	99,240					6.00
7.00	00700	OPERATION OF PLANT	0	1,977				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	1,101			7.01
9.00	00900	HOUSEKEEPING	4,796	96	0	42,939		9.00
10.00	01000	DIETARY	6,522	130	0	2,965	61,725	10.00
11.00	01100	CAFETERIA	2,228	44	0	1,013	32,322	11.00
13.00	01300	NURSING ADMINISTRATION	283	6	0	129	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,713	114	0	2,597	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,112	281	0	6,416	7,754	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,971	199	0	4,533	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,437	148	0	3,381	0	54.00
60.00	06000	LABORATORY	2,815	56	0	1,280	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	236	5	0	107	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,783	36	0	810	0	65.00
66.00	06600	PHYSICAL THERAPY	4,287	85	0	1,949	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,174	43	0	988	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,101	22	0	501	0	68.00
69.00	06900	ELECTROCARDIOLOGY	255	5	0	116	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,657	73	0	1,663	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,629	32	0	741	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,101	0	0	88.00
90.00	09000	CLINIC	18,365	366	0	8,350	0	90.00
90.02	09002	GEROPSYCH	6,439	128	0	2,928	0	90.02
91.00	09100	EMERGENCY	5,437	108	0	2,472	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,240	1,977	1,101	42,939	40,076	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	19,956	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,693	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	99,240	1,977	1,101	42,939	61,725	202.00

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	51,875					11.00
13.00	01300	NURSING ADMINISTRATION	836	4,456				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,888	0	61,635			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,097		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,900	2,110	7,454		162,260	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,633	290	1,715		93,259	50.00
53.00	05300	ANESTHESIOLOGY	793	0	0		919	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,264	0	3,790		86,424	54.00
60.00	06000	LABORATORY	6,888	0	2,888		46,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		2,289	62.00
65.00	06500	RESPIRATORY THERAPY	336	60	668		17,314	65.00
66.00	06600	PHYSICAL THERAPY	3,531	0	3,285		47,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,066	0	0		22,306	67.00
68.00	06800	SPEECH PATHOLOGY	485	0	0		11,304	68.00
69.00	06900	ELECTROCARDIOLOGY	1,249	221	1,390		6,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		32,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		20,969	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	13,103		201,964	88.00
90.00	09000	CLINIC	2,685	476	11,894		187,268	90.00
90.02	09002	GEROPSYCH	1,787	317	0		60,846	90.02
91.00	09100	EMERGENCY	5,534	982	15,448		89,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,875	4,456	61,635	0	1,089,668	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		21,644	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		0	194.01
194.02	07952	FOUNDATION	0	0	0		274	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		1,693	194.03
194.04	07954	VACANT SPACE	0	0	0		0	194.04
200.00		Cross Foot Adjustments				2,097	2,097	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,875	4,456	61,635	2,097	1,115,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.02	00592	HOSPITAL BUSINESS OFFICE			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL			5.04
5.05	00590	OTHER ADMIN. & GENERAL			5.05
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC			7.01
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	162,260	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	93,259	50.00
53.00	05300	ANESTHESIOLOGY	0	919	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,424	54.00
60.00	06000	LABORATORY	0	46,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,289	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,314	65.00
66.00	06600	PHYSICAL THERAPY	0	47,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,304	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,969	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	201,964	88.00
90.00	09000	CLINIC	0	187,268	90.00
90.02	09002	GEROPSYCH	0	60,846	90.02
91.00	09100	EMERGENCY	0	89,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,089,668	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	21,644	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	194.01
194.02	07952	FOUNDATION	0	274	194.02
194.03	07953	OUTPATIENT MEALS	0	1,693	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		Cross Foot Adjustments	0	2,097	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,115,376	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet B-1

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
			1.00	1.01	1.02	2.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,899					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	13,300				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				55,899		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	8,565,283	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	204,264	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	344,140	5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,860	0	0	4,860	659,806	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,611	0	0	5,611	198,373	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	60,031	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	66,651	7.01
9.00	00900	HOUSEKEEPING	2,034	0	0	2,034	267,283	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	329,688	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	102,438	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	401,978	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	197,455	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	787,251	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	139,871	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	0	0	3,154	532,283	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	552,915	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	0	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	756	0	0	756	28,451	65.00
66.00	06600	PHYSICAL THERAPY	1,818	0	0	1,818	196,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	0	922	170,370	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	86,608	68.00
69.00	06900	ELECTROCARDIOLOGY	108	0	0	108	96,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	0	0	1,551	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	0	0	691	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,300	9,400	0	2,178,155	88.00
90.00	09000	CLINIC	7,789	0	0	7,789	209,740	90.00
90.02	09002	GEROPSYCH	2,731	0	0	2,731	135,936	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	416,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,899	13,300	9,400	55,899	8,362,864	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	182,722	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	19,697	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	528,727	130,663	29,670	426,316	3,372,621	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.458613	9.824286	3.156383	7.626541	0.393755	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	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: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet B-1

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description			HOSPITAL BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMIN. & GENERAL (ACCUM. COST)	
			5.02	5A.04	5.04	5A.05	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	32,476,382					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-772,881	20,442,526			5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	2,318,215	-2,405,862	19,231,157	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	442,830	0	459,573	6.00
7.00	00700	OPERATION OF PLANT	0	0	259,453	0	269,262	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	144,500	0	149,963	7.01
9.00	00900	HOUSEKEEPING	0	0	432,446	0	448,796	9.00
10.00	01000	DIETARY	0	0	636,506	0	660,571	10.00
11.00	01100	CAFETERIA	0	0	16,145	0	16,755	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	151,210	0	156,927	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	646,338	0	670,775	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	275,204	0	285,609	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,802,449	0	1,309,360	0	1,358,864	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	983,880	0	349,723	0	362,945	50.00
53.00	05300	ANESTHESIOLOGY	362,609	0	16,506	0	17,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,450,498	0	1,511,386	0	1,568,528	54.00
60.00	06000	LABORATORY	6,620,577	0	1,553,649	0	1,612,389	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	80,722	0	30,349	0	31,496	62.00
65.00	06500	RESPIRATORY THERAPY	171,918	0	92,438	0	95,933	65.00
66.00	06600	PHYSICAL THERAPY	1,190,162	0	436,612	0	453,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	462,865	0	299,439	0	310,760	67.00
68.00	06800	SPEECH PATHOLOGY	309,660	0	159,619	0	165,654	68.00
69.00	06900	ELECTROCARDIOLOGY	1,801,532	0	242,061	0	251,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	322,127	0	83,950	0	87,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,830,155	0	887,163	0	920,705	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,406,920	0	3,599,403	0	3,735,482	88.00
90.00	09000	CLINIC	3,384,558	0	1,582,148	0	1,641,966	90.00
90.02	09002	GEROPSYCH	90,100	0	339,518	0	352,354	90.02
91.00	09100	EMERGENCY	2,205,650	0	2,626,355	0	2,725,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,476,382	-772,881	20,442,526	-2,405,862	18,809,545	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-362,643	0	0	362,643	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	-58,969	0	0	58,969	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	366,821		772,881		2,405,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011295		0.037808		0.125102	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		57,047		89,504	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002791		0.004654	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: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet B-1

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING- RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS	42,089				6.00
7.00	00700	OPERATION OF PLANT	0	42,089			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	13,300		7.01
9.00	00900	HOUSEKEEPING	2,034	2,034	0	40,055	9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	10.00
11.00	01100	CAFETERIA	945	945	0	945	11.00
13.00	01300	NURSING ADMINISTRATION	120	120	0	120	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	2,423	0	2,423	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,985	5,985	0	5,985	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,229	4,229	0	4,229	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	3,154	0	3,154	54.00
60.00	06000	LABORATORY	1,194	1,194	0	1,194	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	100	0	100	62.00
65.00	06500	RESPIRATORY THERAPY	756	756	0	756	65.00
66.00	06600	PHYSICAL THERAPY	1,818	1,818	0	1,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	922	0	922	67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	68.00
69.00	06900	ELECTROCARDIOLOGY	108	108	0	108	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	1,551	0	1,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	691	0	691	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	13,300	0	88.00
90.00	09000	CLINIC	7,789	7,789	0	7,789	90.00
90.02	09002	GEROPSYCH	2,731	2,731	0	2,731	90.02
91.00	09100	EMERGENCY	2,306	2,306	0	2,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,089	42,089	13,300	40,055	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	11,833	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	1,004	194.03
194.04	07954	VACANT SPACE	0	0	0	0	194.04
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)	517,067	302,947	168,724	544,569	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.285086	7.197771	12.686015	22.805524	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	99,240	1,977	1,101	61,725	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.357861	0.046972	0.082782	1.686429	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: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet B-1

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NRS ING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		11.00	13.00	16.00	19.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC					7.01
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	10,799				11.00
13.00	01300	NURSING ADMINISTRATION	174	65,746			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,434	0	3,415		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,477	31,138	413	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	340	4,273	95	0	50.00
53.00	05300	ANESTHESIOLOGY	165	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304	0	210	0	54.00
60.00	06000	LABORATORY	1,434	0	160	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	70	880	37	0	65.00
66.00	06600	PHYSICAL THERAPY	735	0	182	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	260	3,266	77	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	726	0	88.00
90.00	09000	CLINIC	559	7,023	659	0	90.00
90.02	09002	GEROPSYCH	372	4,683	0	0	90.02
91.00	09100	EMERGENCY	1,152	14,483	856	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,799	65,746	3,415	100	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	194.04
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)	487,200	188,378	899,534	321,339	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.115288	2.865239	263.406735	3,213.390000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,875	4,456	61,635	2,097	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.803686	0.067776	18.048316	20.970000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet C
Part I
Date/Time Prepared:
7/23/2019 10:39 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
1.00			2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,141,451		2,141,451	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	600,845		600,845	0	0	50.00
53.00	05300	ANESTHESIOLOGY	348,056		348,056	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,983,228		1,983,228	0	0	54.00
60.00	06000	LABORATORY	1,960,437		1,960,437	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,745		38,745	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	148,367	0	148,367	0	0	65.00
66.00	06600	PHYSICAL THERAPY	651,042	0	651,042	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,151	0	390,151	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	206,382	0	206,382	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	327,582		327,582	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,328		149,328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,058,745		1,058,745	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,562,762		4,562,762	0	0	88.00
90.00	09000	CLINIC	2,323,953		2,323,953	0	0	90.00
90.02	09002	GEROPSYCH	516,972		516,972	0	0	90.02
91.00	09100	EMERGENCY	3,461,862		3,461,862	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	217,261		217,261		0	92.00
200.00		Subtotal (see instructions)	21,087,169	0	21,087,169	0	0	200.00
201.00		Less Observation Beds	217,261		217,261		0	201.00
202.00		Total (see instructions)	20,869,908	0	20,869,908	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet C Part I Date/Time Prepared: 7/23/2019 10:39 am				
				Title XVIII			Hospital		Cost			
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio					
			Inpatient	Outpatient	Total (col. 6 + col. 7)							
			6.00	7.00	8.00							
										9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS	1,620,084		1,620,084					30.00		
ANCILLARY SERVICE COST CENTERS												
50.00	05000	OPERATING ROOM	0	983,880	983,880	0.610689	0.000000			50.00		
53.00	05300	ANESTHESIOLOGY	0	362,609	362,609	0.959866	0.000000			53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,779	8,305,719	8,450,498	0.234688	0.000000			54.00		
60.00	06000	LABORATORY	445,772	6,174,805	6,620,577	0.296113	0.000000			60.00		
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,532	64,190	80,722	0.479981	0.000000			62.00		
65.00	06500	RESPIRATORY THERAPY	0	171,918	171,918	0.863010	0.000000			65.00		
66.00	06600	PHYSICAL THERAPY	107,960	1,082,202	1,190,162	0.547020	0.000000			66.00		
67.00	06700	OCCUPATIONAL THERAPY	103,645	359,220	462,865	0.842905	0.000000			67.00		
68.00	06800	SPEECH PATHOLOGY	9,852	299,808	309,660	0.666479	0.000000			68.00		
69.00	06900	ELECTROCARDIOLOGY	60,429	1,741,103	1,801,532	0.181835	0.000000			69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	263,190	58,937	322,127	0.463569	0.000000			71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000			72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	453,466	1,376,689	1,830,155	0.578500	0.000000			73.00		
OUTPATIENT SERVICE COST CENTERS												
88.00	08800	RURAL HEALTH CLINIC	0	2,406,920	2,406,920					88.00		
90.00	09000	CLINIC	2,483	3,382,075	3,384,558	0.686634	0.000000			90.00		
90.02	09002	GEROPSYCH	0	90,100	90,100	5.737758	0.000000			90.02		
91.00	09100	EMERGENCY	9,276	2,196,374	2,205,650	1.569543	0.000000			91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,552	180,813	182,365	1.191353	0.000000			92.00		
200.00		Subtotal (see instructions)	3,239,020	29,237,362	32,476,382					200.00		
201.00		Less Observation Beds								201.00		
202.00		Total (see instructions)	3,239,020	29,237,362	32,476,382					202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

Period:
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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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.02	09002	GEROPSYCH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-1333

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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,141,451		2,141,451	0	2,141,451	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	600,845		600,845	0	600,845	50.00	
53.00	05300	ANESTHESIOLOGY	348,056		348,056	0	348,056	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,983,228		1,983,228	0	1,983,228	54.00	
60.00	06000	LABORATORY	1,960,437		1,960,437	0	1,960,437	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,745		38,745	0	38,745	62.00	
65.00	06500	RESPIRATORY THERAPY	148,367	0	148,367	0	148,367	65.00	
66.00	06600	PHYSICAL THERAPY	651,042	0	651,042	0	651,042	66.00	
67.00	06700	OCCUPATIONAL THERAPY	390,151	0	390,151	0	390,151	67.00	
68.00	06800	SPEECH PATHOLOGY	206,382	0	206,382	0	206,382	68.00	
69.00	06900	ELECTROCARDIOLOGY	327,582		327,582	0	327,582	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,328		149,328	0	149,328	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,058,745		1,058,745	0	1,058,745	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,562,762		4,562,762	0	4,562,762	88.00	
90.00	09000	CLINIC	2,323,953		2,323,953	0	2,323,953	90.00	
90.02	09002	GEROPSYCH	516,972		516,972	0	516,972	90.02	
91.00	09100	EMERGENCY	3,461,862		3,461,862	0	3,461,862	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	217,261		217,261		217,261	92.00	
200.00		Subtotal (see instructions)	21,087,169	0	21,087,169	0	21,087,169	200.00	
201.00		Less Observation Beds	217,261		217,261		217,261	201.00	
202.00		Total (see instructions)	20,869,908	0	20,869,908	0	20,869,908	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

Period:
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,620,084		1,620,084		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	983,880	983,880	0.610689	0.000000
53.00	05300	ANESTHESIOLOGY	0	362,609	362,609	0.959866	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,779	8,305,719	8,450,498	0.234688	0.000000
60.00	06000	LABORATORY	445,772	6,174,805	6,620,577	0.296113	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,532	64,190	80,722	0.479981	0.000000
65.00	06500	RESPIRATORY THERAPY	0	171,918	171,918	0.863010	0.000000
66.00	06600	PHYSICAL THERAPY	107,960	1,082,202	1,190,162	0.547020	0.000000
67.00	06700	OCCUPATIONAL THERAPY	103,645	359,220	462,865	0.842905	0.000000
68.00	06800	SPEECH PATHOLOGY	9,852	299,808	309,660	0.666479	0.000000
69.00	06900	ELECTROCARDIOLOGY	60,429	1,741,103	1,801,532	0.181835	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	263,190	58,937	322,127	0.463569	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	453,466	1,376,689	1,830,155	0.578500	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,406,920	2,406,920	1.895685	0.000000
90.00	09000	CLINIC	2,483	3,382,075	3,384,558	0.686634	0.000000
90.02	09002	GEROPSYCH	0	90,100	90,100	5.737758	0.000000
91.00	09100	EMERGENCY	9,276	2,196,374	2,205,650	1.569543	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,552	180,813	182,365	1.191353	0.000000
200.00		Subtotal (see instructions)	3,239,020	29,237,362	32,476,382		
201.00		Less Observation Beds					
202.00		Total (see instructions)	3,239,020	29,237,362	32,476,382		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

Period:
From 03/01/2018
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
90.02	09002	GEROPSYCH	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet D Part II Date/Time Prepared: 7/23/2019 10:39 am
Title XVIII				Hospital		Cost
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	93,259	983,880	0.094787	0	0	50.00
53.00 05300 ANESTHESIOLOGY	919	362,609	0.002534	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	86,424	8,450,498	0.010227	77,741	795	54.00
60.00 06000 LABORATORY	46,167	6,620,577	0.006973	203,706	1,420	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,289	80,722	0.028357	13,480	382	62.00
65.00 06500 RESPIRATORY THERAPY	17,314	171,918	0.100711	0	0	65.00
66.00 06600 PHYSICAL THERAPY	47,526	1,190,162	0.039932	12,130	484	66.00
67.00 06700 OCCUPATIONAL THERAPY	22,306	462,865	0.048191	10,300	496	67.00
68.00 06800 SPEECH PATHOLOGY	11,304	309,660	0.036505	2,736	100	68.00
69.00 06900 ELECTROCARDIOLOGY	6,927	1,801,532	0.003845	51,898	200	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32,531	322,127	0.100988	148,618	15,009	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20,969	1,830,155	0.011457	260,013	2,979	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	201,964	2,406,920	0.083910	0	0	88.00
90.00 09000 CLINIC	187,268	3,384,558	0.055330	0	0	90.00
90.02 09002 GEROPSYCH	60,846	90,100	0.675316	0	0	90.02
91.00 09100 EMERGENCY	89,395	2,205,650	0.040530	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16,462	182,365	0.090270	0	0	92.00
200.00 Total (lines 50 through 199)	943,870	30,856,298		780,622	21,865	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet D
Part IV
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Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	321,339	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.02	09002	GEROPSYCH	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	321,339	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019	Worksheet D Part IV Date/Time Prepared: 7/23/2019 10:39 am	
				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	983,880	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	321,339	0	362,609	0.886186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,450,498	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,620,577	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	80,722	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	171,918	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,190,162	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	462,865	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	309,660	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,801,532	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	322,127	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,830,155	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,406,920	0.000000	88.00
90.00	09000	CLINIC	0	0	0	3,384,558	0.000000	90.00
90.02	09002	GEROPSYCH	0	0	0	90,100	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,205,650	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	182,365	0.000000	92.00
200.00		Total (lines 50 through 199)	0	321,339	0	30,856,298		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet D
Part IV
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Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	77,741	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	203,706	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	13,480	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	12,130	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	10,300	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,736	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	51,898	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	148,618	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	260,013	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		780,622	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet D
Part V
Date/Time Prepared:
7/23/2019 10:39 am

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.610689	0	325,554	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.959866	0	105,442	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.234688	0	3,133,978	3	0	54.00
60.00	06000	LABORATORY	0.296113	0	2,580,513	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.479981	0	30,839	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.863010	0	76,526	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547020	0	396,760	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.842905	0	33,337	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666479	0	12,183	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181835	0	799,391	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.463569	0	55,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.578500	0	808,170	450	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.686634	0	1,847,273	1,405	0	90.00
90.02	09002	GEROPSYCH	5.737758	0	88,908	0	0	90.02
91.00	09100	EMERGENCY	1.569543	0	777,245	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.191353	0	98,538	0	0	92.00
200.00		Subtotal (see instructions)		0	11,170,340	1,858	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	11,170,340	1,858	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1333		Period: D From 03/01/2018 To 02/28/2019		Worksheet D Part V Date/Time Prepared: 7/23/2019 10:39 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				Costs					
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
				6.00	7.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	198,812	0					50.00
53.00	05300	ANESTHESIOLOGY	101,210	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	735,507	1					54.00
60.00	06000	LABORATORY	764,123	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,802	0					62.00
65.00	06500	RESPIRATORY THERAPY	66,043	0					65.00
66.00	06600	PHYSICAL THERAPY	217,036	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	28,100	0					67.00
68.00	06800	SPEECH PATHOLOGY	8,120	0					68.00
69.00	06900	ELECTROCARDIOLOGY	145,357	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,813	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	467,526	260					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	1,268,400	965					90.00
90.02	09002	GEROPSYCH	510,133	0					90.02
91.00	09100	EMERGENCY	1,219,919	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	117,394	0					92.00
200.00		Subtotal (see instructions)	5,888,295	1,226					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	5,888,295	1,226					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1333

Period:

Worksheet D

Component CCN:14-Z333

From 03/01/2018
To 02/28/2019Part V
Date/Time Prepared:
7/23/2019 10:39 am

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.610689	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.959866	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.234688	0	0	0	54.00
60.00	06000	LABORATORY	0.296113	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.479981	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.863010	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547020	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.842905	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666479	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181835	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.463569	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.578500	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000	CLINIC	0.686634	0	0	0	90.00
90.02	09002	GEROPSYCH	5.737758	0	0	0	90.02
91.00	09100	EMERGENCY	1.569543	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.191353	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1333

Period:

Worksheet D

Component CCN:14-Z333

From 03/01/2018
To 02/28/2019Part V
Date/Time Prepared:
7/23/2019 10:39 am

			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.02	09002	GEROPSYCH	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet D-1 Date/Time Prepared: 7/23/2019 10:39 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,491	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		914	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)		768	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		433	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)		86	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		48	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)		10	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		551	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)		378	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)		75	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		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,141,451	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)		7,460	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		1,554	25.00
26.00	Total swing-bed cost (see instructions)		781,333	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,360,118	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,360,118	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)		1,488.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		819,938	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)		819,938	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet D-1

Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					330,925	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,150,863	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)					562,498	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					111,607	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					674,105	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)					146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,488.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					217,261	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1333		Period: From 03/01/2018 To 02/28/2019		Worksheet D-1 Date/Time Prepared: 7/23/2019 10:39 am	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	162,260	2,141,451	0.075771	217,261	16,462	90.00
91.00	Nursing School cost	0	2,141,451	0.000000	217,261	0	91.00
92.00	Allied health cost	0	2,141,451	0.000000	217,261	0	92.00
93.00	All other Medical Education	0	2,141,451	0.000000	217,261	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet D-3 Date/Time Prepared: 7/23/2019 10:39 am	
		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		918,438		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.610689	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.959866	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.234688	77,741	18,245	54.00
60.00	06000 LABORATORY	0.296113	203,706	60,320	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.479981	13,480	6,470	62.00
65.00	06500 RESPIRATORY THERAPY	0.863010	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.547020	12,130	6,635	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.842905	10,300	8,682	67.00
68.00	06800 SPEECH PATHOLOGY	0.666479	2,736	1,823	68.00
69.00	06900 ELECTROCARDIOLOGY	0.181835	51,898	9,437	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.463569	148,618	68,895	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.578500	260,013	150,418	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.686634	0	0	90.00
90.02	09002 GEROPSYCH	5.737758	0	0	90.02
91.00	09100 EMERGENCY	1.569543	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.191353	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		780,622	330,925	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		780,622		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet D-3	
		Component CCN: 14-Z333		Date/Time Prepared: 7/23/2019 10:39 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.610689	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.959866	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.234688	11,127	2,611	54.00
60.00	06000 LABORATORY	0.296113	54,237	16,060	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.479981	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.863010	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.547020	73,555	40,236	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.842905	71,795	60,516	67.00
68.00	06800 SPEECH PATHOLOGY	0.666479	7,116	4,743	68.00
69.00	06900 ELECTROCARDIOLOGY	0.181835	4,757	865	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.463569	47,600	22,066	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.578500	158,076	91,447	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.686634	0	0	90.00
90.02	09002 GEROPSYCH	5.737758	0	0	90.02
91.00	09100 EMERGENCY	1.569543	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.191353	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		428,263	238,544	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		428,263		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet E Part B Date/Time Prepared: 7/23/2019 10:39 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,889,521	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)		5,889,521	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,948,416	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)		42,406	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,710,894	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)		4,195,116	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)		4,195,116	30.00
31.00	Primary payer payments		1,565	31.00
32.00	Subtotal (line 30 minus line 31)		4,193,551	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)		259,231	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		168,500	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		259,231	36.00
37.00	Subtotal (see instructions)		4,362,051	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,362,051	40.00
40.01	Sequestration adjustment (see instructions)		87,241	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,864,252	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		410,558	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet E-1
Part I
Date/Time Prepared:
7/23/2019 10:39 am

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		808,523		3,864,252	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	09/11/2018	33,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		33,900		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)		842,423		3,864,252	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		179,280		410,558	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,021,703		4,274,810	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1333

Period:

Worksheet E-1

Component CCN:14-Z333

From 03/01/2018
To 02/28/2019Part I
Date/Time Prepared:
7/23/2019 10:39 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		762,065		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	09/11/2018	43,400		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		43,400		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)		805,465		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		86,384		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		891,849		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet E-1 Part II Date/Time Prepared: 7/23/2019 10:39 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet E-2
		Component CCN:14-Z333		Date/Time Prepared: 7/23/2019 10:39 am
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		680,846	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)		240,929	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		453	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)		921,775	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		921,775	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)		921,775	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,725	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)		910,050	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)		910,050	0 19.00
19.01	Sequestration adjustment (see instructions)		18,201	0 19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0 19.02
20.00	Interim payments		805,465	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)		86,384	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: 14-1333	Period: From 03/01/2018 To 02/28/2019	Worksheet E-3 Part V Date/Time Prepared: 7/23/2019 10:39 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,150,863	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)		1,150,863	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,162,372	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)		1,162,372	19.00
20.00	Deductibles (exclude professional component)		146,372	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,016,000	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,016,000	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		40,853	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		26,554	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		40,853	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,042,554	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)		1,042,554	30.00
30.01	Sequestration adjustment (see instructions)		20,851	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		842,423	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)		179,280	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet G

Date/Time Prepared:
7/23/2019 10:39 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	8,226,810	0	0	0	1.00
2.00 Temporary investments	166,943	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	3,621,584	0	0	0	4.00
5.00 Other receivable	972,250	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	490,452	0	0	0	7.00
8.00 Prepaid expenses	37,907	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	13,515,946	0	0	0	11.00
FIXED ASSETS					
12.00 Land	426,152	0	0	0	12.00
13.00 Land improvements	1,240,691	0	0	0	13.00
14.00 Accumulated depreciation	-942,666	0	0	0	14.00
15.00 Buildings	6,745,387	0	0	0	15.00
16.00 Accumulated depreciation	-4,398,193	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	12,464,671	0	0	0	19.00
20.00 Accumulated depreciation	-9,296,302	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	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	6,239,740	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	4,458,076	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	6,342,615	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	10,800,691	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	30,556,377	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	272,433	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,047,223	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	62,368	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	198,080	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	1,580,104	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	427,962	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	9,892,633	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	10,320,595	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	11,900,699	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	18,655,678				52.00
53.00 Specific purpose fund		0			53.00
54.00 Donor created - endowment fund balance - restricted			0		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	18,655,678	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	30,556,377	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet G-1

Date/Time Prepared:
7/23/2019 10:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		20,844,043		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-140,603				2.00
3.00	Total (sum of line 1 and line 2)		20,703,440		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,703,440		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	2,047,762		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,047,762		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,655,678		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	PRIOR PERIOD ADJUSTMENT		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
7/23/2019 10:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,550,825		1,550,825	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	355,494		355,494	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)	1,906,319		1,906,319	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)	1,906,319		1,906,319	17.00
18.00	Ancillary services	1,520,114	21,398,454	22,918,568	18.00
19.00	Outpatient services	14,979	7,892,043	7,907,022	19.00
20.00	RURAL HEALTH CLINIC	0	2,407,213	2,407,213	20.00
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	CULBERTSON GARDENS	0	332,274	332,274	27.00
27.01	DIETARY	0	2,464	2,464	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,441,412	32,032,448	35,473,860	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,659,324		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	PATIENT COLLECT FEES-OTHER REV	61,426			37.00
38.00	INTEREST EXPENSE	31,213			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)		92,639		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,566,685		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2018
To 02/28/2019

Worksheet G-3

Date/Time Prepared:
7/23/2019 10:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,473,860	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,302,916	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,170,944	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,566,685	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,395,741	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	64,769	6.00
7.00	Income from investments	109,689	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	394,724	24.00
24.01	PROPERTY TAXES	668,576	24.01
24.02	NONCAPITAL GRANTS AND GIFTS	48,593	24.02
25.00	Total other income (sum of lines 6-24)	1,286,351	25.00
26.00	Total (line 5 plus line 25)	-109,390	26.00
27.00	INTEREST EXPENSE	31,213	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	31,213	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-140,603	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333

Period:

Worksheet M-1

Component CCN: 14-3483

From 03/01/2018
To 02/28/2019Date/Time Prepared:
7/23/2019 10:39 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	627,912	10,501	638,413	0	638,413
2.00	Physician Assistant	171,261	0	171,261	0	171,261
3.00	Nurse Practitioner	400,852	0	400,852	0	400,852
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	596,332	0	596,332	0	596,332
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	20,550	0	20,550	0	20,550
8.00	Laboratory Technician	81,981	0	81,981	-81,981	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,898,888	10,501	1,909,389	-81,981	1,827,408
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	121,692	121,692	0	121,692
14.00	Subtotal (sum of lines 11 through 13)	0	121,692	121,692	0	121,692
15.00	Medical Supplies	0	148,636	148,636	0	148,636
16.00	Transportation (Health Care Staff)	0	24,231	24,231	0	24,231
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	172,867	172,867	0	172,867
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,898,888	305,060	2,203,948	-81,981	2,121,967
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	0	0	0	0
30.00	Administrative Costs	427,899	106,043	533,942	-86,182	447,760
31.00	Total Facility Overhead (sum of lines 29 and 30)	427,899	106,043	533,942	-86,182	447,760
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,326,787	411,103	2,737,890	-168,163	2,569,727

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333

Period:

Worksheet M-1

Component CCN: 14-3483

From 03/01/2018
To 02/28/2019Date/Time Prepared:
7/23/2019 10:39 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-4,663	633,750	1.00
2.00	Physician Assistant	0	171,261	2.00
3.00	Nurse Practitioner	0	400,852	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	596,332	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	20,550	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)	-4,663	1,822,745	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	121,692	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	121,692	14.00
15.00	Medical Supplies	0	148,636	15.00
16.00	Transportation (Health Care Staff)	0	24,231	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	172,867	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-4,663	2,117,304	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	0	29.00
30.00	Administrative Costs	-10,838	436,922	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,838	436,922	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,501	2,554,226	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1333

Period:

Worksheet M-2

Component CCN: 14-3483

From 03/01/2018
To 02/28/2019Date/Time Prepared:
7/23/2019 10:39 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.92	3,915	4,200	8,064		1.00
2.00	Physician Assistant	1.45	2,783	2,100	3,045		2.00
3.00	Nurse Practitioner	3.59	8,202	2,100	7,539		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.96	14,900		18,648	18,648	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	0.37	381			381	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.33	15,281			19,029	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,117,304	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)					2,117,304	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)					436,922	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,008,536	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,445,458	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,445,458	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,445,458	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,562,762	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1333 Component CCN:14-3483	Period: From 03/01/2018 To 02/28/2019	Worksheet M-3 Date/Time Prepared: 7/23/2019 10:39 am		
			Title XVIII	RHC I	Cost	
					1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,562,762	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			23,866	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,538,896	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,029	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			19,029	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			238.53	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			238.53	238.53	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	3,846	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	917,386	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	49	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	11,688	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	11,688	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	929,074	16.00
16.01	Total program charges (see instructions)(from contractor's records)				512,358	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				3,041	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				5,514	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.)				681,162	16.04
16.05	Total program cost (see instructions)			0	686,676	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				72,108	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				87,402	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				686,676	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				4,723	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				691,399	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)				691,399	26.00
26.01	Sequestration adjustment (see instructions)				13,828	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				702,436	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)				-24,865	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:14-1333 Component CCN:14-3483	Period: From 03/01/2018 To 02/28/2019	Worksheet M-4 Date/Time Prepared: 7/23/2019 10:39 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,822,745	1,822,745	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000624	0.001806	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,137	3,292	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,099	3,546	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,236	6,838	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,117,304	2,117,304	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,445,458	2,445,458	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002001	0.003230	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,893	7,899	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		9,129	14,737	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		289	836	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		31.59	17.63	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		39	198	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,232	3,491	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)			23,866	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)			4,723	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1333 Component CCN:14-3483	Period: From 03/01/2018 To 02/28/2019	Worksheet M-5 Date/Time Prepared: 7/23/2019 10:39 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		469,536	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		09/11/2018	232,900	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)		232,900	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		702,436	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		24,865	6.02	
7.00	Total Medicare program liability (see instructions)		677,571	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00