

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/11/2019 2:18 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/11/2019	Time: 2:18 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL (14-1338) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title 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	40,003	447,425	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	-16,795	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		179,176		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
200.00	Total	0	23,208	626,601	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: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/11/2019 2:18 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1900 STATE STREET			PO Box:				1.00		
2.00	City: CHESTER			State: IL		Zip Code: 62233		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MEMORIAL HOSPITAL	141338	99914	1	09/01/2004	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL-SWING BEDS	142338	99914		09/01/2004	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		CHESTER CLINIC	148543	99914		06/01/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		STEELEVILLE FAMILY PRACTICE	148542	99914		06/01/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						8			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1338

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/11/2019 2:18 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	61.20
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00
			Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00		2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				0.00	0.00	0.000000	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)								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	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)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	
			1.00	2.00	
			Speech	Respiratory	
			3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	N	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/11/2019 2:18 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	261,518	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/11/2019 2:18 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	06/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/11/2019 2:18 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/29/2019	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1338

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

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1338

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

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/11/2019 2:18 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	28,920.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	28,920.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	28,920.00	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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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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)	560	100	1,205			1.00
2.00 HMO and other (see instructions)	142	25				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	198	0	438			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	758	100	1,657			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)	758	100	1,657	0.00	186.51	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)	6,370	0	22,000	0.00	45.99	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	232.50	27.00
28.00 Observation Bed Days		12	149			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: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/11/2019 2:18 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	168	16	347	1.00
2.00 HMO and other (see instructions)			44	4		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	168	16	347	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: 14-1338
 Component CCN: 14-8543

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

Worksheet S-8

 Date/Time Prepared:
 11/11/2019 2:18 pm

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		2319 OLD PLANK		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		CHESTER IL 62223		2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		1.00		2.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		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 2		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		CHESTER CLINIC		14.00
14.01			STEELEVILLE FAMILY PRACTICE CLINIC		14.01
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County		RANDOLPH		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		6.00		7.00	10.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1338

Period:

Worksheet S-8

Component CCN: 14-8543

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/11/2019 2:18 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1338

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

Worksheet S-10

Date/Time Prepared:
11/11/2019 2:18 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.548563	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,465,919	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		2,532,339	6.00
7.00	Medicaid cost (line 1 times line 6)		1,389,147	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,220	57,847	66,067
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,509	57,847	62,356
22.00	Payments received from patients for amounts previously written off as charity care	100	2,694	2,794
23.00	Cost of charity care (line 21 minus line 22)	4,409	55,153	59,562
			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)		274,844	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		178,649	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		274,844	27.01
28.00	Non-Medicare bad debt expense (see instructions)		0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		96,195	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		155,757	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		155,757	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,187,290	1,187,290	-633,334	553,956	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	801,436	801,436	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,602	2,472,415	2,635,017	0	2,635,017	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,373,466	1,362,583	2,736,049	483,097	3,219,146	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	453,387	535,660	989,047	0	989,047	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,025	48,269	98,294	0	98,294	8.00
9.00	00900	HOUSEKEEPING	271,915	77,541	349,456	0	349,456	9.00
10.00	01000	DIETARY	347,793	196,735	544,528	-435,179	109,349	10.00
11.00	01100	CAFETERIA	0	0	0	435,179	435,179	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	313,827	50,402	364,229	0	364,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,435	700,260	766,695	-692,060	74,635	14.00
15.00	01500	PHARMACY	349,281	406,601	755,882	-303,491	452,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	433,059	78,167	511,226	0	511,226	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,689,237	187,139	1,876,376	0	1,876,376	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	635,951	220,475	856,426	-66,000	790,426	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,664	688,993	1,438,657	0	1,438,657	54.00
60.00	06000	LABORATORY	700,167	730,064	1,430,231	-22,382	1,407,849	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	29,057	64,937	93,994	0	93,994	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	7,733	7,733	0	7,733	64.00
65.00	06500	RESPIRATORY THERAPY	248,109	104,214	352,323	-488	351,835	65.00
66.00	06600	PHYSICAL THERAPY	0	398,248	398,248	0	398,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72,503	72,503	0	72,503	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,362	51,362	0	51,362	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	461,954	461,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	230,106	230,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	303,491	303,491	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	202,831	1,096,794	1,299,625	0	1,299,625	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,766,504	2,076,030	4,842,534	-562,329	4,280,205	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	212,710	105,950	318,660	0	318,660	90.00
91.00	09100	EMERGENCY	621,354	1,765,010	2,386,364	0	2,386,364	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)	11,677,374	14,685,375	26,362,749	0	26,362,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,489	271	3,760	0	3,760	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	11,680,863	14,685,646	26,366,509	0	26,366,509	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	553,956	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,055	798,381	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,635,017	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-103,624	3,115,522	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-3,037	986,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	98,294	8.00
9.00	00900	HOUSEKEEPING	0	349,456	9.00
10.00	01000	DIETARY	-2,902	106,447	10.00
11.00	01100	CAFETERIA	-56,096	379,083	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	364,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-705	73,930	14.00
15.00	01500	PHARMACY	-187,944	264,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,756	498,470	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,876,376	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	790,426	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,496	1,437,161	54.00
60.00	06000	LABORATORY	0	1,407,849	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	93,994	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	7,733	64.00
65.00	06500	RESPIRATORY THERAPY	-47,847	303,988	65.00
66.00	06600	PHYSICAL THERAPY	0	398,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72,503	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,362	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-68,315	393,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	230,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	303,491	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.01	03951	CHEMOTHERAPY	-151,290	1,148,335	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-911,697	3,368,508	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	-79,897	238,763	90.00
91.00	09100	EMERGENCY	-1,169,200	1,217,164	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)	-2,799,861	23,562,888	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,760	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,799,861	23,566,648	200.00

RECLASSIFICATIONS

Provider CCN: 14-1338

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

Worksheet A-6

Date/Time Prepared:
11/11/2019 2:18 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DRUG COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	303,491	1.00	
	0		0	303,491		
	B - RECLASS DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	711,305	1.00	
	0		0	711,305		
	C - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	461,954	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	230,106	2.00	
	0		0	692,060		
	F - CAFETERIA					
1.00	CAFETERIA	11.00	277,951	157,228	1.00	
	0		277,951	157,228		
	H - LEASE/RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	90,131	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	0		0	90,131		
	I - RHC ADMINISTRATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	324,943	237,386	1.00	
	0		324,943	237,386		
	L - RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	77,971	1.00	
	0		0	77,971		
500.00	Grand Total: Increases		602,894	2,269,572	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
11/11/2019 2:18 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS DRUG COST						1.00
	PHARMACY _____	15.00	0	303,491	0		
	0		0	303,491			
1.00	B - RECLASS DEPRECIATION						1.00
	CAP REL COSTS-BLDG & FIXT _____	1.00	0	711,305	9		
	0		0	711,305			
1.00	C - RECLASS MEDICAL SUPPLIES						1.00
	CENTRAL SERVICES & SUPPLY _____	14.00	0	692,060	0		
	2.00	0	0	0	0		
1.00	F - CAFETRIA						1.00
	DIETARY _____	10.00	277,951	157,228	0		
	0		277,951	157,228			
1.00	H - LEASE/RENTAL						1.00
	OPERATING ROOM _____	50.00	0	66,000	10		
	2.00	LABORATORY _____	60.00	0	22,382	0	
3.00	RESPIRATORY THERAPY _____	65.00	0	488	0	3.00	
4.00	ADMINISTRATIVE & GENERAL _____	5.00	0	1,261	0	4.00	
	0		0	90,131			
1.00	I - RHC ADMINISTRATION						1.00
	RURAL HEALTH CLINIC _____	88.00	324,943	237,386	0		
	0		324,943	237,386			
1.00	L - RECLASS PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL _____	5.00	0	77,971	12		
	0		0	77,971			
500.00	Grand Total: Decreases		602,894	2,269,572		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/11/2019 2:18 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	232,983	0	0	0	0	1.00	
2.00	Land Improvements	599,332	100,431	0	100,431	0	2.00	
3.00	Buildings and Fixtures	16,081,363	1,352,236	0	1,352,236	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	964,814	35,964	0	35,964	0	5.00	
6.00	Movable Equipment	11,429,304	819,983	0	819,983	66,768	6.00	
7.00	HIT designated Assets	1,687,027	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	30,994,823	2,308,614	0	2,308,614	66,768	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	30,994,823	2,308,614	0	2,308,614	66,768	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	232,983	0				1.00	
2.00	Land Improvements	699,763	0				2.00	
3.00	Buildings and Fixtures	17,433,599	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	1,000,778	0				5.00	
6.00	Movable Equipment	12,182,519	0				6.00	
7.00	HIT designated Assets	1,687,027	0				7.00	
8.00	Subtotal (sum of lines 1-7)	33,236,669	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	33,236,669	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,187,290	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,187,290	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,187,290				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,187,290				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,134,141	0	19,134,141	0.579758	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,869,546	0	13,869,546	0.420242	0	2.00
3.00	Total (sum of lines 1-2)	33,003,687	0	33,003,687	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	475,985	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	708,250	90,131	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,184,235	90,131	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	77,971	0	0	553,956	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	798,381	2.00
3.00	Total (sum of lines 1-2)	0	77,971	0	0	1,352,337	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-187,944	PHARMACY	15.00	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	-2,259	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,448,234			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	A	-3,037	OPERATION OF PLANT	7.00	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	-54,016	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-68,315	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,756	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN 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)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-3,055	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.00	NON ALLOW LOBBYING DUES	A	-9,332	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	NON ALLOW SALARY	A	-2,891	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON ALLOW OTHER	A	-65,065	ADMINISTRATIVE & GENERAL	5.00	0	35.02
40.00	CRNA AND SURGEON BILLING EXPENS	A	-94,272	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	RHC CRNA EXPENSE	A	-561,000	RURAL HEALTH CLINIC	88.00	0	41.00
42.00	RHC SURGEON	A	-248,926	RURAL HEALTH CLINIC	88.00	0	42.00
42.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.01
44.01	NON ALLOW DR MEALS	A	-2,902	DIETARY	10.00	0	44.01
45.00	REIMB. OF SALARY EXP	B	-7,399	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	REIMB. OF SALARY EXP	B	-6,084	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MISC REV PET SCANNER	B	-400	RADIOLOGY-DIAGNOSTIC	54.00	0	45.02
45.03	NON OP REV	B	-17,993	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	NON OP REV	B	-2,080	CAFETERIA	11.00	0	45.04
45.05	NON OP REV	B	-705	CENTRAL SERVICES & SUPPLY	14.00	0	45.05
45.06	NON OP REV	B	-1,096	RADIOLOGY-DIAGNOSTIC	54.00	0	45.06
45.07	NON OP REV	B	-100	RURAL HEALTH CLINIC	88.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,799,861				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: 14-1338

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

Worksheet A-8-2

Date/Time Prepared:
11/11/2019 2:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.00	AGGREGATE-CLINIC	79,897	79,897	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	1,676,415	1,169,200	507,215	0	0	2.00
3.00	76.01	AGGREGATE-CHEMOTHERAPY	151,290	151,290	0	0	0	3.00
4.00	60.00	AGGREGATE-LABORATORY	20,942	0	20,942	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	47,122	47,122	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	725	725	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,976,391	1,448,234	528,157		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	90.00	AGGREGATE-CLINIC	0	0	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	2.00
3.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	0	0	3.00
4.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	90.00	AGGREGATE-CLINIC	0	0	0	79,897		1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,169,200		2.00
3.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	151,290		3.00
4.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	47,122		5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	725		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,448,234		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/11/2019 2:18 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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	682.65	2,711.60	4,269.20	2,721.92	0.00	9.00
10.00	AHSEA (see instructions)	83.61	83.61	62.70	41.80	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.81	41.81	31.35			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					57,076	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					226,717	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					267,679	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					551,472	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					113,776	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)					665,248	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)					665,248	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)					0	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)					0	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)					0	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)					0	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: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/11/2019 2:18 pm

					Physical Therapy	Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.61	62.70	41.80	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)					665,248	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					665,248	63.00
64.00	Total cost of outside supplier services (from your records)					389,901	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					0	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					0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/11/2019 2:18 pm		
				Occupational Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	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	8.60	1,439.23	82.76	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	79.23	59.43	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.62	39.62	29.72			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						114,030	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						4,918	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						118,948	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)						118,948	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)						118,948	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)						0	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)						0	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)						0	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)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/11/2019 2:18 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.23	59.43	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					118,948	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					118,948	63.00
64.00	Total cost of outside supplier services (from your records)					72,503	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					0	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					0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/11/2019 2:18 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	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	286.55	612.44	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	76.14	76.14	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.07	38.07	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						21,818	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						46,631	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)						68,449	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)						68,449	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)						68,449	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)						0	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)						0	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)						0	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)						0	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: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/11/2019 2:18 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						68,449	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						68,449	63.00
64.00	Total cost of outside supplier services (from your records)						24,475	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						0	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						0	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: 14-1338

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

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	553,956	553,956			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	798,381		798,381		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,635,017	3,699	5,332	2,644,048	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,115,522	114,171	164,549	494,640	3,888,882
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	986,010	80,159	115,528	132,078	1,313,775
8.00	00800	LAUNDRY & LINEN SERVICE	98,294	4,494	6,476	14,573	123,837
9.00	00900	HOUSEKEEPING	349,456	6,592	9,501	79,213	444,762
10.00	01000	DIETARY	106,447	2,716	3,915	21,245	134,323
11.00	01100	CAFETERIA	379,083	15,416	22,217	80,072	496,788
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	364,229	8,262	11,908	91,423	475,822
14.00	01400	CENTRAL SERVICES & SUPPLY	73,930	7,563	10,900	19,354	111,747
15.00	01500	PHARMACY	264,447	4,973	7,167	101,751	378,338
16.00	01600	MEDICAL RECORDS & LIBRARY	498,470	10,588	15,260	126,157	650,475
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,876,376	48,553	69,977	492,100	2,487,006
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	790,426	54,124	78,006	185,262	1,107,818
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,437,161	31,745	45,752	218,388	1,733,046
60.00	06000	LABORATORY	1,407,849	18,044	26,005	203,969	1,655,867
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	93,994	908	1,308	8,465	104,675
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	7,733	0	0	0	7,733
65.00	06500	RESPIRATORY THERAPY	303,988	9,498	13,688	72,278	399,452
66.00	06600	PHYSICAL THERAPY	398,248	60,408	87,062	0	545,718
67.00	06700	OCCUPATIONAL THERAPY	72,503	0	0	0	72,503
68.00	06800	SPEECH PATHOLOGY	51,362	0	0	0	51,362
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	393,639	0	0	0	393,639
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	230,106	0	0	0	230,106
73.00	07300	DRUGS CHARGED TO PATIENTS	303,491	0	0	0	303,491
76.00	03950	CARDIAC REHAB	0	0	0	0	0
76.01	03951	CHEMOTHERAPY	1,148,335	15,258	21,990	59,088	1,244,671
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,368,508	0	0	0	3,368,508
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
90.00	09000	CLINIC	238,763	17,773	25,614	61,966	344,116
91.00	09100	EMERGENCY	1,217,164	26,590	38,322	181,010	1,463,086
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,562,888	541,534	780,477	2,643,032	23,531,546
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,760	5,496	7,921	1,016	18,193
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,088	4,451	0	7,539
193.01	19301	AFTER CARE PROGRAM	0	3,838	5,532	0	9,370
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	23,566,648	553,956	798,381	2,644,048	23,566,648

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

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

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,888,882					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	259,639	0	1,573,414			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,474	0	19,864	168,175		8.00
9.00	00900	HOUSEKEEPING	87,897	0	29,142	0	561,801	9.00
10.00	01000	DIETARY	26,546	0	12,008	0	4,425	10.00
11.00	01100	CAFETERIA	98,179	0	68,146	0	25,115	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	94,036	0	36,525	0	13,461	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,084	0	33,432	0	12,321	14.00
15.00	01500	PHARMACY	74,770	0	21,982	0	8,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,552	0	46,805	0	17,250	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	491,502	0	214,636	168,175	79,101	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	218,936	0	239,265	0	88,178	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	342,498	0	140,333	0	51,718	54.00
60.00	06000	LABORATORY	327,246	0	79,764	0	29,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,687	0	4,012	0	1,479	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,528	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	78,943	0	41,986	0	15,473	65.00
66.00	06600	PHYSICAL THERAPY	107,849	0	267,042	0	98,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,329	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,151	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77,794	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,475	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,978	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	245,982	0	67,450	0	24,858	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	665,716	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	68,007	0	78,566	0	28,955	90.00
91.00	09100	EMERGENCY	289,147	0	117,543	0	43,319	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)	3,881,945	0	1,518,501	168,175	541,564	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,595	0	24,294	0	8,953	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,490	0	13,652	0	5,031	192.00
193.01	19301	AFTER CARE PROGRAM	1,852	0	16,967	0	6,253	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,888,882	0	1,573,414	168,175	561,801	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	177,302					10.00
11.00	01100	CAFETERIA	0	688,228				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	34,529	0	654,373		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,310	0	0	186,894	14.00
15.00	01500	PHARMACY	0	38,430	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,647	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	177,302	185,861	0	362,771	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	69,971	0	121,283	5,967	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,482	0	0	852	54.00
60.00	06000	LABORATORY	0	77,036	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,197	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,298	0	0	1,147	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	68	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	116,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	56,622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	22,316	0	36,880	574	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,022	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	23,403	0	0	355	90.00
91.00	09100	EMERGENCY	0	68,364	0	133,439	1,877	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)	177,302	687,844	0	654,373	186,894	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	384	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	177,302	688,228	0	654,373	186,894	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	521,621					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	890,729				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	44,743	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	58,993	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,102	0	0	0	54.00
60.00	06000	LABORATORY	0	204,162	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,462	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	4,861	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	40,246	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	44,389	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,924	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,261	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	95,594	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,103	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,361	41,881	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	349,590	51,036	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	55,670	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	9,760	0	0	0	90.00
91.00	09100	EMERGENCY	0	65,212	0	0	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)	521,621	890,729	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	521,621	890,729	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,211,097	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,910,411	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,554,031	0	54.00
60.00	06000	LABORATORY	0	0	0	2,373,471	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	139,512	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	14,122	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	604,545	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,063,480	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	93,756	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	65,774	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	683,437	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	342,306	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	521,711	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	2,043,357	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,092,916	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	553,162	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,181,987	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)	0	0	0	23,449,075	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	55,419	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	27,712	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	34,442	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	23,566,648	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		4,211,097	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.01	03951	CHEMOTHERAPY	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		23,449,075	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.01	19301	AFTER CARE PROGRAM	193.01
194.00	07950	NON-ALLOWABLE COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,699	5,332	9,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	114,171	164,549	278,720	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	80,159	115,528	195,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,494	6,476	10,970	8.00
9.00	00900	HOUSEKEEPING	0	6,592	9,501	16,093	9.00
10.00	01000	DIETARY	0	2,716	3,915	6,631	10.00
11.00	01100	CAFETERIA	0	15,416	22,217	37,633	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	8,262	11,908	20,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,563	10,900	18,463	14.00
15.00	01500	PHARMACY	0	4,973	7,167	12,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,588	15,260	25,848	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	48,553	69,977	118,530	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	54,124	78,006	132,130	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,745	45,752	77,497	54.00
60.00	06000	LABORATORY	0	18,044	26,005	44,049	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	908	1,308	2,216	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,498	13,688	23,186	65.00
66.00	06600	PHYSICAL THERAPY	0	60,408	87,062	147,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	15,258	21,990	37,248	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	17,773	25,614	43,387	90.00
91.00	09100	EMERGENCY	0	26,590	38,322	64,912	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	541,534	780,477	1,322,011	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,496	7,921	13,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,088	4,451	7,539	192.00
193.01	19301	AFTER CARE PROGRAM	0	3,838	5,532	9,370	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	553,956	798,381	1,352,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	280,408					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	18,721	0	214,859			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,765	0	2,713	15,498		8.00
9.00	00900	HOUSEKEEPING	6,338	0	3,980	0	26,682	9.00
10.00	01000	DIETARY	1,914	0	1,640	0	210	10.00
11.00	01100	CAFETERIA	7,079	0	9,306	0	1,193	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,780	0	4,988	0	639	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,592	0	4,565	0	585	14.00
15.00	01500	PHARMACY	5,391	0	3,002	0	385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,269	0	6,392	0	819	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,440	0	29,310	15,498	3,757	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,786	0	32,673	0	4,188	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,696	0	19,163	0	2,456	54.00
60.00	06000	LABORATORY	23,596	0	10,892	0	1,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,492	0	548	0	70	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	110	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,692	0	5,733	0	735	65.00
66.00	06600	PHYSICAL THERAPY	7,776	0	36,464	0	4,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,033	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	732	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,609	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,279	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,325	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	17,737	0	9,211	0	1,181	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	48,003	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	4,904	0	10,729	0	1,375	90.00
91.00	09100	EMERGENCY	20,849	0	16,051	0	2,057	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)	279,908	0	207,360	15,498	25,721	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	259	0	3,318	0	425	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107	0	1,864	0	239	192.00
193.01	19301	AFTER CARE PROGRAM	134	0	2,317	0	297	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	280,408	0	214,859	15,498	26,682	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	10,468					10.00
11.00	01100	CAFETERIA	0	55,484				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,784	0	35,673		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	589	0	0	25,860	14.00
15.00	01500	PHARMACY	0	3,098	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,841	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,468	14,984	0	19,777	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,641	0	6,612	826	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,650	0	0	118	54.00
60.00	06000	LABORATORY	0	6,210	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	258	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,201	0	0	159	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	16,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	1,799	0	2,010	79	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	418	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	1,887	0	0	49	90.00
91.00	09100	EMERGENCY	0	5,511	0	7,274	260	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)	10,468	55,453	0	35,673	25,860	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,468	55,484	0	35,673	25,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	24,364					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,600				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,341	0			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,086	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,626	0			54.00
60.00	06000	LABORATORY	0	10,680	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	286	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	254	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	2,106	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,322	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	362	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	223	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,001	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	529	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,435	2,191	0			73.00
76.00	03950	CARDIAC REHAB	0	0	0			76.00
76.01	03951	CHEMOTHERAPY	16,329	2,670	0			76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,600	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	0	511	0			90.00
91.00	09100	EMERGENCY	0	3,412	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)	24,364	46,600	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0			193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0			194.00
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)	24,364	46,600	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				251,786	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				201,575	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				141,952	0	54.00
60.00	06000	LABORATORY				97,520	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				4,899	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				364	0	64.00
65.00	06500	RESPIRATORY THERAPY				40,059	0	65.00
66.00	06600	PHYSICAL THERAPY				198,716	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				1,395	0	67.00
68.00	06800	SPEECH PATHOLOGY				955	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				26,717	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				11,643	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				11,951	0	73.00
76.00	03950	CARDIAC REHAB				0	0	76.00
76.01	03951	CHEMOTHERAPY				88,466	0	76.01
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				51,021	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				0	0	88.01
90.00	09000	CLINIC				63,054	0	90.00
91.00	09100	EMERGENCY				120,944	0	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	0	0	1,313,017	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				17,453	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				9,749	0	192.00
193.01	19301	AFTER CARE PROGRAM				12,118	0	193.01
194.00	07950	NON-ALLOWABLE COSTS				0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,352,337	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

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

Cost Center Description			Total	
			26.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	251,786	30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	201,575	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,952	54.00
60.00	06000	LABORATORY	97,520	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,899	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
64.00	06400	INTRAVENOUS THERAPY	364	64.00
65.00	06500	RESPIRATORY THERAPY	40,059	65.00
66.00	06600	PHYSICAL THERAPY	198,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,395	67.00
68.00	06800	SPEECH PATHOLOGY	955	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,951	73.00
76.00	03950	CARDIAC REHAB	0	76.00
76.01	03951	CHEMOTHERAPY	88,466	76.01
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	51,021	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
90.00	09000	CLINIC	63,054	90.00
91.00	09100	EMERGENCY	120,944	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)	1,313,017	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,749	192.00
193.01	19301	AFTER CARE PROGRAM	12,118	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,352,337	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQ FEET)	MVBLE EQUIP (SQ FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,897					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		87,897				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	587	587	9,076,250			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,116	18,116	1,697,959	-3,888,882	19,677,766	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,719	12,719	453,387	0	1,313,775	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713	713	50,025	0	123,837	8.00
9.00	00900	HOUSEKEEPING	1,046	1,046	271,915	0	444,762	9.00
10.00	01000	DIETARY	431	431	72,928	0	134,323	10.00
11.00	01100	CAFETERIA	2,446	2,446	274,865	0	496,788	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,311	1,311	313,827	0	475,822	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,200	1,200	66,435	0	111,747	14.00
15.00	01500	PHARMACY	789	789	349,281	0	378,338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,680	1,680	433,059	0	650,475	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,704	7,704	1,689,237	0	2,487,006	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,588	8,588	635,951	0	1,107,818	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,037	5,037	749,664	0	1,733,046	54.00
60.00	06000	LABORATORY	2,863	2,863	700,167	0	1,655,867	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144	144	29,057	0	104,675	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	7,733	64.00
65.00	06500	RESPIRATORY THERAPY	1,507	1,507	248,109	0	399,452	65.00
66.00	06600	PHYSICAL THERAPY	9,585	9,585	0	0	545,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	72,503	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	51,362	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	393,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	230,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	303,491	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,421	2,421	202,831	0	1,244,671	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,368,508	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	2,820	2,820	212,710	0	344,116	90.00
91.00	09100	EMERGENCY	4,219	4,219	621,354	0	1,463,086	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)	85,926	85,926	9,072,761	-3,888,882	19,642,664	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	872	872	3,489	0	18,193	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	490	490	0	0	7,539	192.00
193.01	19301	AFTER CARE PROGRAM	609	609	0	0	9,370	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	553,956	798,381	2,644,048		3,888,882	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.302331	9.083143	0.291315		0.197628	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,031		280,408	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000995		0.014250	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQ FEET)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	56,475				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	713	1,205			8.00
9.00	00900	HOUSEKEEPING	0	1,046	0	54,716		9.00
10.00	01000	DIETARY	0	431	0	431	1,205	10.00
11.00	01100	CAFETERIA	0	2,446	0	2,446	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,311	0	1,311	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,200	0	1,200	0	14.00
15.00	01500	PHARMACY	0	789	0	789	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,680	0	1,680	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	7,704	1,205	7,704	1,205	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,588	0	8,588	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,037	0	5,037	0	54.00
60.00	06000	LABORATORY	0	2,863	0	2,863	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	144	0	144	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,507	0	1,507	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,585	0	9,585	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	2,421	0	2,421	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	2,820	0	2,820	0	90.00
91.00	09100	EMERGENCY	0	4,219	0	4,219	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)	0	54,504	1,205	52,745	1,205	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	872	0	872	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	490	0	490	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	609	0	609	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,573,414	168,175	561,801	177,302	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.860363	139.564315	10.267582	147.138589	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	214,859	15,498	26,682	10,468	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.804498	12.861411	0.487645	8.687137	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,255,171					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	313,827	0	3,047,072			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,435	0	0	759,519		14.00
15.00	01500	PHARMACY	349,281	0	0	0	1,360,484	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	433,059	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,689,237	0	1,689,237	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	635,951	0	564,749	24,248	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,664	0	0	3,464	0	54.00
60.00	06000	LABORATORY	700,167	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	29,057	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	248,109	0	0	4,661	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	276	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	473,083	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	230,106	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	303,491	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	202,831	0	171,732	2,334	911,795	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,280	145,198	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	212,710	0	0	1,441	0	90.00
91.00	09100	EMERGENCY	621,354	0	621,354	7,626	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)	6,251,682	0	3,047,072	759,519	1,360,484	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,489	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	688,228	0	654,373	186,894	521,621	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.110025	0.000000	0.214755	0.246069	0.383408	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,484	0	35,673	25,860	24,364	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008870	0.000000	0.011707	0.034048	0.017908	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (COSTED REQUIS.)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,071,481					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,862,188	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,455,294	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,453,069	0	0	0	0	54.00
60.00	06000	LABORATORY	8,496,628	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	227,341	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	202,328	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,675,038	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,847,449	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,193	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	177,350	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,978,597	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	420,477	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,743,068	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,124,121	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	406,208	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,714,132	0	0	0	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)	37,071,481	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	890,729	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024027	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,600	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001257	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet B-1
Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

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

				Title XVIII		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	4,211,097		4,211,097	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,910,411		1,910,411	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,554,031		2,554,031	0	0	54.00	
60.00	06000	LABORATORY	2,373,471		2,373,471	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,512		139,512	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	14,122		14,122	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	604,545	0	604,545	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,063,480	0	1,063,480	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	93,756	0	93,756	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	65,774	0	65,774	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	683,437		683,437	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,306		342,306	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	521,711		521,711	0	0	73.00	
76.00	03950	CARDIAC REHAB	0		0	0	0	76.00	
76.01	03951	CHEMOTHERAPY	2,043,357		2,043,357	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	4,092,916		4,092,916	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01	
90.00	09000	CLINIC	553,162		553,162	0	0	90.00	
91.00	09100	EMERGENCY	2,181,987		2,181,987	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	349,959		349,959	0	0	92.00	
200.00		Subtotal (see instructions)	23,799,034	0	23,799,034	0	0	200.00	
201.00		Less Observation Beds	349,959		349,959	0	0	201.00	
202.00		Total (see instructions)	23,449,075	0	23,449,075	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/11/2019 2:18 pm	
					Title XVIII		Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,654,742		1,654,742			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	204,664	2,250,630	2,455,294	0.778078	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	407,247	8,045,822	8,453,069	0.302142	0.000000	54.00
60.00	06000	LABORATORY	779,443	7,717,185	8,496,628	0.279343	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	72,106	155,235	227,341	0.613668	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	1,000	201,328	202,328	0.069798	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	256,110	1,418,928	1,675,038	0.360914	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	206,393	1,641,056	1,847,449	0.575648	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,312	196,881	288,193	0.325324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,954	164,396	177,350	0.370871	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	743,854	3,234,743	3,978,597	0.171778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	207,861	212,616	420,477	0.814090	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,239	1,270,829	1,743,068	0.299306	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.01	03951	CHEMOTHERAPY	0	2,124,121	2,124,121	0.961978	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	409,776	5,265,079	5,674,855			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	475	405,733	406,208	1.361770	0.000000	90.00
91.00	09100	EMERGENCY	10,000	2,704,132	2,714,132	0.803935	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	207,446	207,446	1.686988	0.000000	92.00
200.00		Subtotal (see instructions)	5,530,176	37,216,160	42,746,336			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,530,176	37,216,160	42,746,336			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

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

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 CARDIAC REHAB	0.000000			76.00
76.01	03951 CHEMOTHERAPY	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1338

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

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,211,097		4,211,097	0	4,211,097 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,910,411		1,910,411	0	1,910,411 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,554,031		2,554,031	0	2,554,031 54.00
60.00	06000 LABORATORY	2,373,471		2,373,471	0	2,373,471 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	139,512		139,512	0	139,512 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
64.00	06400 INTRAVENOUS THERAPY	14,122		14,122	0	14,122 64.00
65.00	06500 RESPIRATORY THERAPY	604,545	0	604,545	0	604,545 65.00
66.00	06600 PHYSICAL THERAPY	1,063,480	0	1,063,480	0	1,063,480 66.00
67.00	06700 OCCUPATIONAL THERAPY	93,756	0	93,756	0	93,756 67.00
68.00	06800 SPEECH PATHOLOGY	65,774	0	65,774	0	65,774 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	683,437		683,437	0	683,437 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	342,306		342,306	0	342,306 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	521,711		521,711	0	521,711 73.00
76.00	03950 CARDIAC REHAB	0		0	0	0 76.00
76.01	03951 CHEMOTHERAPY	2,043,357		2,043,357	0	2,043,357 76.01
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LITHOTRIPSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	4,092,916		4,092,916	0	4,092,916 88.00
88.01	08801 RURAL HEALTH CLINIC II	0		0	0	0 88.01
90.00	09000 CLINIC	553,162		553,162	0	553,162 90.00
91.00	09100 EMERGENCY	2,181,987		2,181,987	0	2,181,987 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	349,959		349,959	0	349,959 92.00
200.00	Subtotal (see instructions)	23,799,034	0	23,799,034	0	23,799,034 200.00
201.00	Less Observation Beds	349,959		349,959	0	349,959 201.00
202.00	Total (see instructions)	23,449,075	0	23,449,075	0	23,449,075 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

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

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,654,742		1,654,742			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	204,664	2,250,630	2,455,294	0.778078	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	407,247	8,045,822	8,453,069	0.302142	0.000000	54.00
60.00	06000	LABORATORY	779,443	7,717,185	8,496,628	0.279343	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	72,106	155,235	227,341	0.613668	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	1,000	201,328	202,328	0.069798	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	256,110	1,418,928	1,675,038	0.360914	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	206,393	1,641,056	1,847,449	0.575648	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,312	196,881	288,193	0.325324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,954	164,396	177,350	0.370871	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	743,854	3,234,743	3,978,597	0.171778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	207,861	212,616	420,477	0.814090	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,239	1,270,829	1,743,068	0.299306	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.01	03951	CHEMOTHERAPY	0	2,124,121	2,124,121	0.961978	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	409,776	5,265,079	5,674,855	0.721237	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
90.00	09000	CLINIC	475	405,733	406,208	1.361770	0.000000	90.00
91.00	09100	EMERGENCY	10,000	2,704,132	2,714,132	0.803935	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	207,446	207,446	1.686988	0.000000	92.00
200.00		Subtotal (see instructions)	5,530,176	37,216,160	42,746,336			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,530,176	37,216,160	42,746,336			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

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

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 CARDIAC REHAB	0.000000			76.00
76.01	03951 CHEMOTHERAPY	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1338

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

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)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	201,575	2,455,294	0.082098	98,046	8,049	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	141,952	8,453,069	0.016793	171,217	2,875	54.00
60.00	06000 LABORATORY	97,520	8,496,628	0.011477	309,886	3,557	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	4,899	227,341	0.021549	30,863	665	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	364	202,328	0.001799	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	40,059	1,675,038	0.023915	109,813	2,626	65.00
66.00	06600 PHYSICAL THERAPY	198,716	1,847,449	0.107562	45,476	4,891	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,395	288,193	0.004841	19,132	93	67.00
68.00	06800 SPEECH PATHOLOGY	955	177,350	0.005385	2,240	12	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,717	3,978,597	0.006715	340,062	2,284	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,643	420,477	0.027690	140,214	3,883	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,951	1,743,068	0.006856	171,212	1,174	73.00
76.00	03950 CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	88,466	2,124,121	0.041648	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	51,021	5,674,855	0.008991	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
90.00	09000 CLINIC	63,054	406,208	0.155226	0	0	90.00
91.00	09100 EMERGENCY	120,944	2,714,132	0.044561	2,166	97	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	20,924	207,446	0.100865	0	0	92.00
200.00	Total (lines 50 through 199)	1,082,155	41,091,594		1,440,327	30,206	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1338

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

Worksheet D
Part IV
Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/11/2019 2:18 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	2,455,294	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	8,453,069	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	8,496,628	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	227,341	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	202,328	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,675,038	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,847,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	288,193	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	177,350	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	3,978,597	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	420,477	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	1,743,068	0.000000	73.00
76.00	03950	CARDIAC REHAB		0	0	0	0	0.000000	76.00
76.01	03951	CHEMOTHERAPY		0	0	0	2,124,121	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	5,674,855	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0.000000	88.01
90.00	09000	CLINIC		0	0	0	406,208	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	2,714,132	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	207,446	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	41,091,594		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/11/2019 2:18 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	98,046	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	171,217	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	309,886	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	30,863	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	109,813	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	45,476	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	19,132	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	2,240	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	340,062	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	140,214	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	171,212	0	0	0	73.00
76.00	03950	CARDIAC REHAB		0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	2,166	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,440,327	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/11/2019 2:18 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.778078	0	794,544	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302142	0	2,581,183	0	0	54.00
60.00	06000	LABORATORY	0.279343	0	2,739,605	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	0	92,132	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.069798	0	106,232	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.360914	0	508,037	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.575648	0	602,076	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.325324	0	67,610	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.370871	0	38,906	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	0	1,107,852	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.814090	0	65,627	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299306	0	516,037	1,386	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.961978	0	1,228,299	3,679	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	1.361770	0	152,451	0	0	90.00
91.00	09100	EMERGENCY	0.803935	0	699,371	1,306	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	96,268	0	0	92.00
200.00		Subtotal (see instructions)		0	11,396,230	6,371	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	11,396,230	6,371	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1338		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/11/2019 2:18 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Costs					
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
				6.00	7.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	618,217	0					50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	779,884	0					54.00
60.00	06000	LABORATORY	765,289	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	56,538	0					62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
64.00	06400	INTRAVENOUS THERAPY	7,415	0					64.00
65.00	06500	RESPIRATORY THERAPY	183,358	0					65.00
66.00	06600	PHYSICAL THERAPY	346,584	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	21,995	0					67.00
68.00	06800	SPEECH PATHOLOGY	14,429	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	190,305	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,426	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,453	415					73.00
76.00	03950	CARDIAC REHAB	0	0					76.00
76.01	03951	CHEMOTHERAPY	1,181,597	3,539					76.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
90.00	09000	CLINIC	207,603	0					90.00
91.00	09100	EMERGENCY	562,249	1,050					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	162,403	0					92.00
200.00		Subtotal (see instructions)	5,305,745	5,004					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	5,305,745	5,004					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:

Worksheet D

Component CCN: 14-Z338

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/11/2019 2:18 pm

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.778078	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302142	0	0	0	0	54.00
60.00	06000	LABORATORY	0.279343	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.069798	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.360914	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.575648	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.325324	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.370871	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.814090	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299306	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.961978	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	1.361770	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.803935	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:

Worksheet D

Component CCN: 14-Z338

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/11/2019 2:18 pm

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/11/2019 2:18 pm

			Title XIX		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
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.778078	0	100,930	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302142	0	470,320	0	0	54.00
60.00	06000	LABORATORY	0.279343	0	402,523	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	0	10,518	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.069798	0	51,321	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.360914	0	62,038	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.575648	0	21,870	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.325324	0	5,641	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.370871	0	2,631	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	0	187,486	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.814090	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299306	0	72,620	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.961978	0	2,598	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.721237				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	1.361770	0	21,180	0	0	90.00
91.00	09100	EMERGENCY	0.803935	0	492,831	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	16,910	0	0	92.00
200.00		Subtotal (see instructions)		0	1,921,417	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	1,921,417	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/11/2019 2:18 pm

			Title XIX		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	78,531	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,103	0		54.00
60.00	06000	LABORATORY	112,442	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,455	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	3,582	0		64.00
65.00	06500	RESPIRATORY THERAPY	22,390	0		65.00
66.00	06600	PHYSICAL THERAPY	12,589	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,835	0		67.00
68.00	06800	SPEECH PATHOLOGY	976	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,206	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,736	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	2,499	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	28,842	0		90.00
91.00	09100	EMERGENCY	396,204	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,527	0		92.00
200.00		Subtotal (see instructions)	890,917	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	890,917	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:

11/11/2019 2:18 pm

Title XVIII		Hospital	Cost	
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,354	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)		1,205	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		219	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)		219	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7	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)		7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		560	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)		99	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)		99	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		155.11	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,211,097	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)		1,086	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)		1,114	25.00
26.00	Total swing-bed cost (see instructions)		1,030,935	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,180,162	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)		3,180,162	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,348.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,315,278	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,315,278	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					531,937 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,847,215 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)					232,522 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					232,522 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					465,044 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)					149 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,348.72 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					349,959 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/11/2019 2:18 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	251,786	4,211,097	0.059791	349,959	20,924
91.00	Nursing School cost	0	4,211,097	0.000000	349,959	0
92.00	Allied health cost	0	4,211,097	0.000000	349,959	0
93.00	All other Medical Education	0	4,211,097	0.000000	349,959	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/11/2019 2:18 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,806 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,354 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)			1,205 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			219 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)			219 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			7 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)			7 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			100 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.11 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.14 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,211,097 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)			1,086 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)			1,114 25.00
26.00	Total swing-bed cost (see instructions)			1,030,935 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,180,162 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)			3,180,162 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,348.71 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			234,871 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)			234,871 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Title XIX		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	
		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)					67,762 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					302,633 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)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					149 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,348.72 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					349,959 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/11/2019 2:18 pm

Cost Center Description		Title XIX		Hospital		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	251,786	4,211,097	0.059791	349,959	20,924	90.00
91.00	Nursing School cost	0	4,211,097	0.000000	349,959	0	91.00
92.00	Allied health cost	0	4,211,097	0.000000	349,959	0	92.00
93.00	All other Medical Education	0	4,211,097	0.000000	349,959	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/11/2019 2:18 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		587,533		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.778078	98,046	76,287	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.302142	171,217	51,732	54.00
60.00	06000 LABORATORY	0.279343	309,886	86,564	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	30,863	18,940	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.069798	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.360914	109,813	39,633	65.00
66.00	06600 PHYSICAL THERAPY	0.575648	45,476	26,178	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.325324	19,132	6,224	67.00
68.00	06800 SPEECH PATHOLOGY	0.370871	2,240	831	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	340,062	58,415	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.814090	140,214	114,147	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.299306	171,212	51,245	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.961978	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.361770	0	0	90.00
91.00	09100 EMERGENCY	0.803935	2,166	1,741	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,440,327	531,937	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,440,327		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338 Component CCN: 14-Z338	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/11/2019 2:18 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		158,853		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.778078	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.302142	3,566	1,077	54.00
60.00	06000 LABORATORY	0.279343	26,337	7,357	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	128	79	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.069798	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.360914	17,090	6,168	65.00
66.00	06600 PHYSICAL THERAPY	0.575648	58,731	33,808	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.325324	27,719	9,018	67.00
68.00	06800 SPEECH PATHOLOGY	0.370871	1,249	463	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	32,598	5,600	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.814090	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.299306	30,382	9,094	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.961978	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.361770	0	0	90.00
91.00	09100 EMERGENCY	0.803935	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		197,800	72,664	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		197,800		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/11/2019 2:18 pm	
			Title XIX	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		72,432		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.778078	15,404	11,986	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.302142	32,514	9,824	54.00
60.00	06000	LABORATORY	0.279343	43,769	12,227	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.613668	6,812	4,180	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.069798	999	70	64.00
65.00	06500	RESPIRATORY THERAPY	0.360914	14,124	5,098	65.00
66.00	06600	PHYSICAL THERAPY	0.575648	1,050	604	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.325324	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.370871	320	119	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.171778	49,805	8,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.814090	7,349	5,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299306	25,062	7,501	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.961978	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.721237	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
90.00	09000	CLINIC	1.361770	392	534	90.00
91.00	09100	EMERGENCY	0.803935	1,345	1,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.686988	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		198,945	67,762	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		198,945		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/11/2019 2:18 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,310,749	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)		5,310,749	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,363,856	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		32,047	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,729,814	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)		3,601,995	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)		3,601,995	30.00
31.00	Primary payer payments		2,862	31.00
32.00	Subtotal (line 30 minus line 31)		3,599,133	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)		227,531	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		147,895	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		197,318	36.00
37.00	Subtotal (see instructions)		3,747,028	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,747,028	40.00
40.01	Sequestration adjustment (see instructions)		74,941	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,224,662	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		447,425	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: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/11/2019 2:18 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,568,330		3,117,296	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/26/2018	15,978	12/26/2018	59,415	3.01
3.02		06/19/2019	51,865	06/19/2019	47,951	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)		67,843		107,366	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,636,173		3,224,662	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		40,003		447,425	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,676,176		3,672,087	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: 14-1338

Period:

Worksheet E-1

Component CCN: 14-Z338

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

11/11/2019 2:18 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		582,271		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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/19/2019	33,253		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)		-33,253		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)		549,018		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		16,795		0	6.02
7.00	Total Medicare program liability (see instructions)		532,223		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: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/11/2019 2:18 pm	
		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1338

Period:

Worksheet E-2

Component CCN: 14-Z338

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/11/2019 2:18 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		469,694	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)		73,391	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		198	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)		543,085	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		543,085	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)		543,085	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	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)		543,085	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)		543,085	0	19.00
19.01	Sequestration adjustment (see instructions)		10,862	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		549,018	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)		-16,795	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: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/11/2019 2:18 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,847,215	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)		1,847,215	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,865,687	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)		1,865,687	19.00
20.00	Deductibles (exclude professional component)		165,761	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,699,926	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,699,926	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		16,089	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		10,458	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,089	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,710,384	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)		1,710,384	30.00
30.01	Sequestration adjustment (see instructions)		34,208	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,636,173	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)		40,003	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1338

Period:
From 07/01/2018
To 06/30/2019Worksheet E-3
Part VII
Date/Time Prepared:
11/11/2019 2:18 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		302,633		1.00
2.00	Medical and other services			890,917	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		302,633	890,917	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		302,633	890,917	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		72,432		8.00
9.00	Ancillary service charges		198,945	1,921,417	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		271,377	1,921,417	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		271,377	1,921,417	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	1,030,500	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		31,256	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		302,633	890,917	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		302,633	890,917	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		31,256	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		302,633	890,917	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		302,633	890,917	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		302,633	890,917	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		302,633	890,917	40.00
41.00	Interim payments		302,633	890,917	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1338

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

Worksheet G

Date/Time Prepared:
11/11/2019 2:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,851,856	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,854,129	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,702,047	0	0	0	6.00
7.00	Inventory	2,586,693	0	0	0	7.00
8.00	Prepaid expenses	0	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)	12,590,631	0	0	0	11.00
FIXED ASSETS						
12.00	Land	232,983	0	0	0	12.00
13.00	Land improvements	699,764	0	0	0	13.00
14.00	Accumulated depreciation	-543,179	0	0	0	14.00
15.00	Buildings	17,433,599	0	0	0	15.00
16.00	Accumulated depreciation	-9,592,702	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	1,000,778	0	0	0	19.00
20.00	Accumulated depreciation	-863,208	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	12,182,519	0	0	0	23.00
24.00	Accumulated depreciation	-10,839,870	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,687,027	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)	11,397,711	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	28,553,268	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,553,268	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,541,610	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	854,286	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,395,272	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,249,558	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,249,558	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	49,292,052				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)	49,292,052	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,541,610	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1338

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

Worksheet G-1

Date/Time Prepared:
11/11/2019 2:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		46,608,402		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,683,650				2.00
3.00	Total (sum of line 1 and line 2)		49,292,052		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)		49,292,052		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,292,052		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1338

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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,622,351		1,622,351	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	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)	1,622,351		1,622,351	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)	1,622,351		1,622,351	17.00
18.00	Ancillary services	3,465,890		3,465,890	18.00
19.00	Outpatient services	0	33,213,135	33,213,135	19.00
20.00	RURAL HEALTH CLINIC	409,776	6,802,822	7,212,598	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,498,017	40,015,957	45,513,974	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,366,509		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,366,509		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1338

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

Worksheet G-3

Date/Time Prepared:
11/11/2019 2:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,513,974	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,075,569	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,438,405	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,366,509	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-928,104	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	527,260	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	187,944	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	54,016	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	68,315	17.00
18.00	Revenue from sale of medical records and abstracts	12,756	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	340B RETAIL PHARMACY NET REV	1,978,546	24.00
24.01	OTHER OPER REV - BUSI UNIT 5000	471,414	24.01
24.02	OTHER NON OP REV	311,503	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	3,611,754	25.00
26.00	Total (line 5 plus line 25)	2,683,650	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,683,650	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/11/2019 2:18 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,176,780	240,446	1,417,226	0	1,417,226	1.00
2.00	Physician Assistant	178,716	36,516	215,232	0	215,232	2.00
3.00	Nurse Practitioner	104,332	21,318	125,650	0	125,650	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	613,762	95,093	708,855	0	708,855	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	98,872	39,014	137,886	0	137,886	8.00
9.00	Other Facility Health Care Staff Costs	141,564	40,427	181,991	0	181,991	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,314,026	472,814	2,786,840	0	2,786,840	10.00
11.00	Physician Services Under Agreement	0	811,158	811,158	0	811,158	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	811,158	811,158	0	811,158	14.00
15.00	Medical Supplies	0	16,772	16,772	0	16,772	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	58,069	58,069	0	58,069	18.00
19.00	Other Health Care Costs	0	350,502	350,502	0	350,502	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	425,343	425,343	0	425,343	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,314,026	1,709,315	4,023,341	0	4,023,341	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	169,338	169,338	0	169,338	29.00
30.00	Administrative Costs	452,478	197,377	649,855	-562,329	87,526	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	452,478	366,715	819,193	-562,329	256,864	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,766,504	2,076,030	4,842,534	-562,329	4,280,205	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/11/2019 2:18 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,417,226		1.00
2.00	Physician Assistant	0	215,232		2.00
3.00	Nurse Practitioner	0	125,650		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	708,855		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	137,886		8.00
9.00	Other Facility Health Care Staff Costs	0	181,991		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,786,840		10.00
11.00	Physician Services Under Agreement	-811,158	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	-811,158	0		14.00
15.00	Medical Supplies	0	16,772		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	58,069		18.00
19.00	Other Health Care Costs	-12,562	337,940		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-12,562	412,781		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-823,720	3,199,621		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	169,338		29.00
30.00	Administrative Costs	-87,977	-451		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-87,977	168,887		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-911,697	3,368,508		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1338

Period:

Worksheet M-2

Component CCN: 14-8543

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/11/2019 2:18 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	4.31	15,010	4,200	18,102		1.00
2.00	Physician Assistant	1.69	4,106	2,100	3,549		2.00
3.00	Nurse Practitioner	0.97	2,884	2,100	2,037		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.97	22,000		23,688	23,688	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.97	22,000			23,688	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,199,621	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,199,621	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)					168,887	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					724,408	15.00
16.00	Total overhead (sum of lines 14 and 15)					893,295	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					893,295	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					893,295	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,092,916	20.00

Health Financial Systems		MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1338	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8543		Date/Time Prepared: 11/11/2019 2:18 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,092,916	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			118,755	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,974,161	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			23,688	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)			23,688	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			167.77	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)		167.77	167.77	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		3,185	3,185	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		534,347	534,347	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,068,694	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,142,153	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			14,807	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			13,855	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.)			751,878	16.04
16.05	Total program cost (see instructions)		0	765,733	16.05
17.00	Primary payer amounts			89	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			114,991	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			205,432	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			765,644	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			35,121	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			800,765	22.00
23.00	Allowable bad debts (see instructions)			31,224	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			20,296	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,224	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)			821,061	26.00
26.01	Sequestration adjustment (see instructions)			16,421	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			625,464	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)			179,176	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: 14-1338 Component CCN: 14-8543	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/11/2019 2:18 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,786,840	2,786,840	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001125	0.007259	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,135	20,230	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		28,094	41,377	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		31,229	61,607	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,199,621	3,199,621	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		893,295	893,295	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.009760	0.019254	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,719	17,200	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		39,948	78,807	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		188	1,489	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		212.49	52.93	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		37	515	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,862	27,259	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)			118,755	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)			35,121	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/11/2019 2:18 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		601,460	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		12/26/2018	10,936		3.01
3.02		06/19/2019	13,068		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)		24,004		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		625,464		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		179,176		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		804,640		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00