

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/1/2019 1:13 pm
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PART I - COST REPORT STATUS

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (14-1349) 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	169,453	-206,712	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	33,177	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		340,054		0	10.00
200.00	Total	0	202,630	133,342	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: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/1/2019 1:13 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 818 EAST BROADWAY			PO Box:				1.00		
2.00	City: SPARTA			State: IL		Zip Code: 62286		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	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		SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	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		
21.00	Type of Control (see instructions)						11			
							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			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/1/2019 1:13 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1349

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	N	N	0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	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
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	412,664		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							

MCRIF32 - 15.8.166.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/1/2019 1:13 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part II Date/Time Prepared: 11/1/2019 1:13 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	N				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/27/2019	Y	09/27/2019		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1349

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

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1349

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/1/2019 1:13 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	22,514.00	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	22,514.00	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	22,514.00	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	101.00				0	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: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/1/2019 1:13 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	641	39	952		1.00
2.00	HMO and other (see instructions)	53	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	709	0	832		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	33		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,350	39	1,817		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,350	39	1,817	0.00	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	4,586	0	9,101	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			14		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	13,440	0	47,416	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		10	404		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			6		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: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/1/2019 1:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	212	13	320	1.00
2.00 HMO and other (see instructions)			17	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	212	13	320	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	0.00					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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-7694		Period: From 07/01/2018 To 06/30/2019		Worksheet S-4 Date/Time Prepared: 11/1/2019 1:13 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	259.00	54.00	259.00	572.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.17	0.00	2.17	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			6.99	0.00	6.99	6.00
7.00	Nursing Supervisor			1.67	0.00	1.67	7.00
8.00	Physical Therapy Service			2.92	0.00	2.92	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.31	0.00	0.31	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.11	0.11	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16060			20.00
20.01				41180			20.01
20.02				99914			20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,001	14	27	83	2,125	21.00
22.00	Skilled Nursing Visit Charges	624,172	4,505	9,278	26,117	664,072	22.00
23.00	Physical Therapy Visits	2,063	65	5	66	2,199	23.00
24.00	Physical Therapy Visit Charges	516,594	15,683	1,863	16,884	551,024	24.00
25.00	Occupational Therapy Visits	174	28	0	5	207	25.00
26.00	Occupational Therapy Visit Charges	54,111	8,355	0	1,558	64,024	26.00
27.00	Speech Pathology Visits	51	0	0	4	55	27.00
28.00	Speech Pathology Visit Charges	15,887	0	0	1,246	17,133	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,289	107	32	158	4,586	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,210,764	28,543	11,141	45,805	1,296,253	35.00
36.00	Total Number of Episodes (standard/non outlier)	284		12	12	308	36.00
37.00	Total Number of Outlier Episodes		3		1	4	37.00
38.00	Total Non-Routine Medical Supply Charges	13,870	0	124	540	14,534	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1349 Component CCN: 14-3464		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/1/2019 1:13 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1300 NORTH MARKET			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			SPARTA IL 62286		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			09:00	14:00	09:00	19:00	09:00	11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y		6		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number			WOMENS HEALTH CLINIC		143464		14.00	
14.01				COULTERVILLE MEDICAL CLINIC		143465		14.01	
14.02				FAMILY HEALTH CLINIC		143466		14.02	
14.03				STEELEVILLE CLINIC		143467		14.03	
14.04				MARISSA MEDICAL CLINIC		143490		14.04	
14.05				SPARTA MEDICAL OFFICE		143489		14.05	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			RANDOLPH				2.00	

MCRIF32 - 15.8.166.2

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/1/2019 1:13 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.374985 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,189,085		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,611,331		5.00
6.00	Medicaid charges	12,510,309		6.00
7.00	Medicaid cost (line 1 times line 6)	4,691,178		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	44,169		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)	112,207	194,160	306,367 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	42,076	194,160	236,236 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	42,076	194,160	236,236 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,651,780		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	786,364		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,209,792		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,441,988		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,339,137		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,575,373		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,575,373		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		690,410	690,410	-110,617	579,793	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	175,470	175,470	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,029,838	1,029,838	26,007	1,055,845	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,442,701	5,442,701	0	5,442,701	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,061,891	2,923,341	5,985,232	-46,582	5,938,650	5.00
6.00	00600	MAINTENANCE & REPAIRS	212,661	12,193	224,854	0	224,854	6.00
7.00	00700	OPERATION OF PLANT	0	603,635	603,635	68,282	671,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,771	46,771	0	46,771	8.00
9.00	00900	HOUSEKEEPING	200,426	192,511	392,937	0	392,937	9.00
10.00	01000	DIETARY	161,500	121,499	282,999	32,750	315,749	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	205,656	1,283	206,939	0	206,939	13.00
15.00	01500	PHARMACY	0	1,903,194	1,903,194	0	1,903,194	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	297,273	68,315	365,588	0	365,588	16.00
17.00	01700	SOCIAL SERVICE	17,241	15,458	32,699	0	32,699	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	605,031	605,031	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,085,415	298,639	1,384,054	21,451	1,405,505	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	558,696	892,661	1,451,357	34,994	1,486,351	50.00
53.00	05300	ANESTHESIOLOGY	39,864	622,510	662,374	-614,291	48,083	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	435,453	181,989	617,442	-57,462	559,980	54.00
54.01	05401	ULTRASOUND	124,469	84,255	208,724	466	209,190	54.01
56.00	05600	RADIOISOTOPE	0	342,202	342,202	4,577	346,779	56.00
57.00	05700	CT SCAN	0	117,417	117,417	36,098	153,515	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	109,708	109,708	21,364	131,072	58.00
60.00	06000	LABORATORY	570,479	1,030,024	1,600,503	-13,932	1,586,571	60.00
65.00	06500	RESPIRATORY THERAPY	49,348	24,796	74,144	-174	73,970	65.00
66.00	06600	PHYSICAL THERAPY	675,397	99,990	775,387	-29,412	745,975	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,427	5,257	40,684	8,889	49,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	123,142	123,142	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	314,069	314,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	129,017	129,017	0	129,017	75.01
75.02	03952	WOUND CENTER	0	158,575	158,575	0	158,575	75.02
76.00	03953	CARDIAC REHAB	103,303	4,426	107,729	0	107,729	76.00
76.01	03030	DIABETES EDUCATION	79,478	3,465	82,943	-32,750	50,193	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,183,174	1,751,941	6,935,115	-191,959	6,743,156	88.00
91.00	09100	EMERGENCY	762,251	1,207,542	1,969,793	-30,590	1,939,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	715,607	206,552	922,159	-40,704	881,455	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		31,137	31,137	-31,137	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,575,009	20,353,252	34,928,261	272,980	35,201,241	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	119,430	471,754	591,184	-271,339	319,845	194.00
194.01	07951	THE CENTER - FITNESS CENTER	65,339	12,002	77,341	-1,641	75,700	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,759,778	20,837,008	35,596,786	0	35,596,786	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-30,320	549,473	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	175,470	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-42,230	1,013,615	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,336,303	4,106,398	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-753,642	5,185,008	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	224,854	6.00
7.00	00700	OPERATION OF PLANT	0	671,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,771	8.00
9.00	00900	HOUSEKEEPING	0	392,937	9.00
10.00	01000	DIETARY	0	315,749	10.00
11.00	01100	CAFETERIA	-39,017	-39,017	11.00
13.00	01300	NURSING ADMINISTRATION	0	206,939	13.00
15.00	01500	PHARMACY	-900,113	1,003,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-365	365,223	16.00
17.00	01700	SOCIAL SERVICE	0	32,699	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-605,031	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-9,900	1,395,605	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-418,916	1,067,435	50.00
53.00	05300	ANESTHESIOLOGY	0	48,083	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-2,924	557,056	54.00
54.01	05401	ULTRASOUND	0	209,190	54.01
56.00	05600	RADIOISOTOPE	0	346,779	56.00
57.00	05700	CT SCAN	0	153,515	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	131,072	58.00
60.00	06000	LABORATORY	0	1,586,571	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,970	65.00
66.00	06600	PHYSICAL THERAPY	0	745,975	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	49,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,786	129,928	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	314,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	75.00
75.01	03951	SLEEP LAB	0	129,017	75.01
75.02	03952	WOUND CENTER	0	158,575	75.02
76.00	03953	CARDIAC REHAB	0	107,729	76.00
76.01	03030	DIABETES EDUCATION	0	50,193	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-12,400	6,730,756	88.00
91.00	09100	EMERGENCY	-364,691	1,574,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	881,455	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,509,066	30,692,175	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	319,845	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	75,700	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,509,066	31,087,720	200.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/1/2019 1:13 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	A - TO RECLASS COST OF SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	123,142	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		72.00	0	314,069	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
				0	437,211	
	B - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	30,320	1.00
2.00	ADMINISTRATIVE & GENERAL		5.00	0	817	2.00
				0	31,137	
	C - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY		69.00	13,932	0	1.00
				13,932	0	
	D - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP RELATED COST		3.00	0	60,540	1.00
				0	60,540	
	E - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL		5.00	0	16,455	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
				0	16,455	
	F - SURGERY-FREESTANDING CLINICS					
1.00	OPERATING ROOM		50.00	0	259,034	1.00
				0	259,034	
	G - TO RECLASS CRNA EXPENSES					
1.00	NONPHYSICIAN ANESTHETISTS		19.00	39,864	565,167	1.00
				39,864	565,167	
	H - TO RECLASS NORTHCAMPUS BLDG					
1.00	CAP REL COSTS-NORTH CAMPUS BLDG		1.01	0	169,863	1.00
				0	169,863	
	I - TO RECLASS CT SCAN					
1.00	CT_SCAN		57.00	36,098	0	1.00
				36,098	0	
	J - TO RECLASS RECRUITMENT EXPENSE					
1.00	RURAL HEALTH CLINIC		88.00	0	32,475	1.00
				0	32,475	
	K - TO RECLASS STRESS TEST SALARIES					
1.00	RADIOISOTOPE		56.00	4,577	0	1.00
2.00	ULTRASOUND		54.01	466	0	2.00
				5,043	0	
	L - TO RECLASS MRI SALARIES					
1.00	MAGNETIC RESONANCE IMAGING (MRI)		58.00	21,364	0	1.00
				21,364	0	
	M - TO RECLASS DIETARY SALARIES					
1.00	DIETARY		10.00	32,750	0	1.00
				32,750	0	
	O - UTILITY EXPENSE					
1.00	OPERATION OF PLANT		7.00	0	68,282	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
				0	68,282	
	P - HOME HEALTH BILLER					
1.00	ADMINISTRATIVE & GENERAL		5.00	29,161	0	1.00
				29,161	0	
	Q - RHC - HOSPITAL SUPPORT					
1.00	ADULTS & PEDIATRICS		30.00	35,000	0	1.00
2.00	OPERATING ROOM		50.00	0	159,882	2.00
				35,000	159,882	
500.00	Grand Total: Increases			213,212	1,800,046	500.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/1/2019 1:13 pm

	Decreases						11/17/2019 1:13 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES						
1.00	OPERATING ROOM	50.00	0	383,922	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	13,265	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	9,260	0		3.00
4.00	EMERGENCY	91.00	0	30,590	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	174	0		5.00
	0		0	437,211			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	31,137	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	31,137			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	13,932	0	0		1.00
	0		13,932	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,540	12		1.00
	0		0	60,540			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	284	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,067	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	9,061	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	4,494	0		4.00
5.00	FREESTANDING CLINICS	194.00	0	1,549	0		5.00
	0		0	16,455			
	F - SURGERY-FREESTANDING CLINICS						
1.00	FREESTANDING CLINICS	194.00	0	259,034	0		1.00
	0		0	259,034			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	39,864	565,167	0		1.00
	0		39,864	565,167			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,863	9		1.00
	0		0	169,863			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	36,098	0	0		1.00
	0		36,098	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,475	0		1.00
	0		0	32,475			
	K - TO RECLASS STRESS TEST SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	5,043	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		5,043	0			
	L - TO RECLASS MRI SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	21,364	0	0		1.00
	0		21,364	0			
	M - TO RECLASS DIETARY SALARIES						
1.00	DIABETES EDUCATION	76.01	32,750	0	0		1.00
	0		32,750	0			
	O - UTILITY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	28,345	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	20,491	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	7,049	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	10,756	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	1,641	0		5.00
	0		0	68,282			
	P - HOME HEALTH BILLER						
1.00	HOME HEALTH AGENCY	101.00	29,161	0	0		1.00
	0		29,161	0			
	Q - RHC - HOSPITAL SUPPORT						
1.00	RURAL HEALTH CLINIC	88.00	35,000	159,882	0		1.00
2.00		0.00	0	0	0		2.00
	0		35,000	159,882			
500.00	Grand Total: Decreases		213,212	1,800,046			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/1/2019 1:13 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	326,334	175,221	0	175,221	145,221	1.00
2.00	Land Improvements	829,135	15,165	0	15,165	5,764	2.00
3.00	Buildings and Fixtures	16,988,984	148,025	0	148,025	37,930	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,446,221	773,072	0	773,072	602,358	6.00
7.00	HIT designated Assets	891,921	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,482,595	1,111,483	0	1,111,483	791,273	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,482,595	1,111,483	0	1,111,483	791,273	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	356,334	0				1.00
2.00	Land Improvements	838,536	0				2.00
3.00	Buildings and Fixtures	17,099,079	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	12,616,935	0				6.00
7.00	HIT designated Assets	891,921	0				7.00
8.00	Subtotal (sum of lines 1-7)	31,802,805	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	31,802,805	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	690,410	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,029,838	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,720,248	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed 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	690,410				1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,029,838				2.00
3.00	Total (sum of lines 1-2)	0	1,720,248				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,025,179	0	15,025,179	0.477801	28,926	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	2,912,435	0	2,912,435	0.092616	5,607	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,508,856	0	13,508,856	0.429583	26,007	2.00
3.00	Total (sum of lines 1-2)	31,446,470	0	31,446,470	1.000000	60,540	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	28,926	520,547	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	5,607	169,863	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	26,007	987,608	0	2.00
3.00	Total (sum of lines 1-2)	0	0	60,540	1,678,018	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	28,926	0	0	549,473	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	5,607	0	0	175,470	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,007	0	0	1,013,615	2.00
3.00	Total (sum of lines 1-2)	0	60,540	0	0	1,738,558	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-30,320	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-817	ADMINISTRATIVE & GENERAL	5.00	11	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	-20,014	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	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	-786,531			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-39,017	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	B	6,786	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-365	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
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-605,031	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
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	-10,171	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-9,001	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-85,078	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-2,358	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHYSICIAN RECRUITMENT COSTS	A	-7,239	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PERSONAL USE OF AUTO	A	-6,531	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-4,636	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING SALARY	A	-38,908	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-85,021	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-14,347	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	LOBBYING EXPENSES	A	-9,002	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	SELF INSURANCE EXPENSE	A	-1,001,972	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MALPRACTICE INSURANCE DIVIDEND	B	-277,792	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	WORKER'S COMPENSATION INSURANCE DIVI	B	-85,412	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	RHC SELF INSURANCE EXPENSE	A	-229,936	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	USAC SUBSIDY	B	-64,256	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	EMPLOYEE ACTIVITIES	B	-404	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	340B CONTRACT DEPRECIATION	A	-1,667	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	340B CONTRACT EXPENSES	A	-900,113	PHARMACY	15.00	0	33.17
33.18	HOSPICE REVENUE	A	-9,900	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	PENALTY/INTEREST LATE TAX DEPOSIT	B	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	LOSS ON IMPAIRMENT	B	-145,221	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	PHYSICIAN ASSISTANT	B	-12,400	RURAL HEALTH CLINIC	88.00	0	33.21
33.22	MRI OFFSET	A	-30,392	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,509,066				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: 14-1349

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

Worksheet A-8-2

Date/Time Prepared:
11/1/2019 1:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	35,000	0	35,000	0	0	1.00
2.00	91.00	EMERGENCY	1,062,282	364,691	697,591	0	0	2.00
3.00	50.00	OPERATING ROOM	259,034	259,034	0	0	0	3.00
4.00	75.01	SLEEP LAB	9,833	0	9,833	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	16,000	0	16,000	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	2,924	2,924	0	0	0	6.00
7.00	60.00	LABORATORY	19,200	0	19,200	0	0	7.00
8.00	50.00	OPERATING ROOM	159,882	159,882	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			1,564,155	786,531	777,624		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	75.01	SLEEP LAB	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	364,691		2.00
3.00	50.00	OPERATING ROOM	0	0	0	259,034		3.00
4.00	75.01	SLEEP LAB	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	2,924		6.00
7.00	60.00	LABORATORY	0	0	0	0		7.00
8.00	50.00	OPERATING ROOM	0	0	0	159,882		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	786,531		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/1/2019 1:13 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						28	1.00
2.00	Line 1 multiplied by 15 hours per week						420	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	0.00	355.50	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	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)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						27,068	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)						27,068	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)						27,068	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						31,979	22.00
23.00	Total salary equivalency (see instructions)						31,979	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: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/1/2019 1:13 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)						31,979	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)						31,979	63.00
64.00	Total cost of outside supplier services (from your records)						14,715	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: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	549,473	549,473			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	175,470	0	175,470		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,013,615			1,013,615	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,106,398	0	0	0	4,106,398
5.00	00500	ADMINISTRATIVE & GENERAL	5,185,008	52,081	35,533	315,822	853,709
6.00	00600	MAINTENANCE & REPAIRS	224,854	26,048	0	1,137	59,483
7.00	00700	OPERATION OF PLANT	671,917	45,106	4,852	46,713	0
8.00	00800	LAUNDRY & LINEN SERVICE	46,771	4,098	0	0	0
9.00	00900	HOUSEKEEPING	392,937	5,567	0	2,422	56,061
10.00	01000	DIETARY	315,749	12,814	0	6,020	54,333
11.00	01100	CAFETERIA	-39,017	7,122	0	0	0
13.00	01300	NURSING ADMINISTRATION	206,939	2,387	0	82	57,524
15.00	01500	PHARMACY	1,003,081	3,592	0	449	0
16.00	01600	MEDICAL RECORDS & LIBRARY	365,223	11,663	8,837	5,229	83,150
17.00	01700	SOCIAL SERVICE	32,699	0	0	0	4,822
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,395,605	51,731	0	36,034	313,389
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,067,435	48,294	0	95,383	156,272
53.00	05300	ANESTHESIOLOGY	48,083	684	0	837	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	557,056	9,650	0	61,023	105,727
54.01	05401	ULTRASOUND	209,190	2,791	0	58,076	34,945
56.00	05600	RADIOISOTOPE	346,779	2,239	0	0	1,280
57.00	05700	CT SCAN	153,515	2,815	0	55,341	10,097
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131,072	7,216	0	183,704	5,976
60.00	06000	LABORATORY	1,586,571	13,988	0	25,959	155,671
65.00	06500	RESPIRATORY THERAPY	73,970	1,423	0	812	13,803
66.00	06600	PHYSICAL THERAPY	745,975	3,740	37,420	26,073	188,914
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	49,573	1,353	0	2,370	12,396
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,928	4,440	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	314,069	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	129,017	4,417	0	236	0
75.02	03952	WOUND CENTER	158,575	11,547	0	0	0
76.00	03953	CARDIAC REHAB	107,729	6,990	0	4,895	28,895
76.01	03030	DIABETES EDUCATION	50,193	1,470	0	0	13,070
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,730,756	109,484	52,955	22,207	1,439,987
91.00	09100	EMERGENCY	1,574,512	23,187	0	35,855	213,208
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	881,455	12,760	0	2,101	192,004
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,692,175	490,697	139,597	988,780	4,054,716
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,555	0	12,299	0
194.00	07950	FREESTANDING CLINICS	319,845	57,221	0	12,536	33,406
194.01	07951	THE CENTER - FITNESS CENTER	75,700	0	35,873	0	18,276
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	31,087,720	549,473	175,470	1,013,615	4,106,398

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,442,153	6,442,153				5.00
6.00	00600	MAINTENANCE & REPAIRS	311,522	81,324	392,846			6.00
7.00	00700	OPERATION OF PLANT	768,588	200,643	29,882	999,113		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,869	13,280	2,715	8,522	75,386	8.00
9.00	00900	HOUSEKEEPING	456,987	119,298	3,688	11,578	0	9.00
10.00	01000	DIETARY	388,916	101,528	8,489	26,649	14	10.00
11.00	01100	CAFETERIA	-31,895	0	4,718	14,812	0	11.00
13.00	01300	NURSING ADMINISTRATION	266,932	69,684	1,581	4,964	0	13.00
15.00	01500	PHARMACY	1,007,122	262,913	2,380	7,471	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	474,102	123,766	14,820	46,522	0	16.00
17.00	01700	SOCIAL SERVICE	37,521	9,795	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,796,759	469,051	34,271	107,581	22,253	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,367,384	356,961	31,994	100,434	15,100	50.00
53.00	05300	ANESTHESIOLOGY	49,604	12,949	453	1,423	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	733,456	191,472	6,393	20,067	2,312	54.00
54.01	05401	ULTRASOUND	305,002	79,622	1,849	5,805	2,922	54.01
56.00	05600	RADIOISOTOPE	350,298	91,447	1,484	4,657	0	56.00
57.00	05700	CT SCAN	221,768	57,893	1,865	5,854	2,880	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,968	85,617	4,780	15,006	2,109	58.00
60.00	06000	LABORATORY	1,782,189	465,248	9,267	29,090	0	60.00
65.00	06500	RESPIRATORY THERAPY	90,008	23,497	943	2,959	0	65.00
66.00	06600	PHYSICAL THERAPY	1,002,122	261,608	32,514	102,067	4,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	65,692	17,149	896	2,814	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	134,368	35,077	2,941	9,233	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	314,069	81,989	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	133,670	34,895	2,926	9,185	0	75.01
75.02	03952	WOUND CENTER	170,122	44,411	7,650	24,013	0	75.02
76.00	03953	CARDIAC REHAB	148,509	38,769	4,631	14,537	0	76.00
76.01	03030	DIABETES EDUCATION	64,733	16,899	974	3,056	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,355,389	2,181,210	87,195	133,436	0	88.00
91.00	09100	EMERGENCY	1,846,762	482,105	15,361	48,220	17,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,088,320	284,110	8,453	26,535	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,521,009	6,294,210	325,113	786,490	69,101	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,854	3,617	1,030	3,234	0	190.00
194.00	07950	FREESTANDING CLINICS	423,008	110,428	37,908	118,997	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	129,849	33,898	28,795	90,392	6,285	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,087,720	6,442,153	392,846	999,113	75,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	591,551					9.00
10.00	01000	DIETARY	1,358	526,954				10.00
11.00	01100	CAFETERIA	9,219	376,886	373,740			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	21,521	364,682		13.00
15.00	01500	PHARMACY	3,381	0	25,299	0	1,308,566	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,378	0	48,134	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,778	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,338	150,068	32,856	144,142	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87,757	0	33,349	112,167	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	11,387	0	10,678	0	0	54.00
54.01	05401	ULTRASOUND	7,557	0	15,442	0	0	54.01
56.00	05600	RADIOISOTOPE	2,731	0	329	0	0	56.00
57.00	05700	CT SCAN	8,439	0	3,943	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	821	0	0	58.00
60.00	06000	LABORATORY	11,604	0	43,699	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,474	0	23,657	6,262	0	65.00
66.00	06600	PHYSICAL THERAPY	16,693	0	52,406	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,308,566	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	3,208	0	0	0	0	75.01
75.02	03952	WOUND CENTER	8,323	0	23,164	0	0	75.02
76.00	03953	CARDIAC REHAB	5,433	0	2,629	0	0	76.00
76.01	03030	DIABETES EDUCATION	1,358	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	188,579	0	7,228	0	0	88.00
91.00	09100	EMERGENCY	70,329	0	12,157	102,111	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,280	0	9,200	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	523,826	526,954	370,290	364,682	1,308,566	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	32,007	0	3,450	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	35,718	0	0	0	0	194.01
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)	591,551	526,954	373,740	364,682	1,308,566	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	711,722					16.00
17.00	01700	SOCIAL SERVICE	0	51,094				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,486	51,094	0	2,941,899	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,527	0	0	2,148,673	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	64,429	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	15,284	0	0	991,049	0	54.00
54.01	05401	ULTRASOUND	6,313	0	0	424,512	0	54.01
56.00	05600	RADIOISOTOPE	6,978	0	0	457,924	0	56.00
57.00	05700	CT SCAN	2,326	0	0	304,968	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,329	0	0	437,630	0	58.00
60.00	06000	LABORATORY	29,240	0	0	2,370,337	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,307	0	0	157,107	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,471,551	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	86,551	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	181,619	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	396,058	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,308,566	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	7,310	0	0	191,194	0	75.01
75.02	03952	WOUND CENTER	3,655	0	0	281,338	0	75.02
76.00	03953	CARDIAC REHAB	997	0	0	215,505	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	87,020	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	410,685	0	0	11,363,722	0	88.00
91.00	09100	EMERGENCY	87,719	0	0	2,682,134	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,419,898	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	680,156	51,094	0	29,983,684	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	21,735	0	190.00
194.00	07950	FREESTANDING CLINICS	31,566	0	0	757,364	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	324,937	0	194.01
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)	711,722	51,094	0	31,087,720	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
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
13.00	01300	NURSING ADMINISTRATION	13.00
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
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Part II
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	102,748	52,081	35,533	315,822	506,184
6.00	00600	MAINTENANCE & REPAIRS	322	26,048	0	1,137	27,507
7.00	00700	OPERATION OF PLANT	37	45,106	4,852	46,713	96,708
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,098	0	0	4,098
9.00	00900	HOUSEKEEPING	81	5,567	0	2,422	8,070
10.00	01000	DIETARY	0	12,814	0	6,020	18,834
11.00	01100	CAFETERIA	0	7,122	0	0	7,122
13.00	01300	NURSING ADMINISTRATION	0	2,387	0	82	2,469
15.00	01500	PHARMACY	4,917	3,592	0	449	8,958
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,663	8,837	5,229	25,729
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,237	51,731	0	36,034	106,002
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	51,524	48,294	0	95,383	195,201
53.00	05300	ANESTHESIOLOGY	30	684	0	837	1,551
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	9,650	0	61,023	70,673
54.01	05401	ULTRASOUND	0	2,791	0	58,076	60,867
56.00	05600	RADIOISOTOPE	0	2,239	0	0	2,239
57.00	05700	CT SCAN	0	2,815	0	55,341	58,156
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,216	0	183,704	190,920
60.00	06000	LABORATORY	15,983	13,988	0	25,959	55,930
65.00	06500	RESPIRATORY THERAPY	13,449	1,423	0	812	15,684
66.00	06600	PHYSICAL THERAPY	0	3,740	37,420	26,073	67,233
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	1,353	0	2,370	3,723
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,440	0	0	4,440
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
75.01	03951	SLEEP LAB	0	4,417	0	236	4,653
75.02	03952	WOUND CENTER	0	11,547	0	0	11,547
76.00	03953	CARDIAC REHAB	0	6,990	0	4,895	11,885
76.01	03030	DIABETES EDUCATION	0	1,470	0	0	1,470
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,753	109,484	52,955	22,207	199,399
91.00	09100	EMERGENCY	7,476	23,187	0	35,855	66,518
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	12,760	0	2,101	14,861
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	229,557	490,697	139,597	988,780	1,848,631
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,555	0	12,299	13,854
194.00	07950	FREESTANDING CLINICS	0	57,221	0	12,536	69,757
194.01	07951	THE CENTER - FITNESS CENTER	0	0	35,873	0	35,873
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	229,557	549,473	175,470	1,013,615	1,968,115

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	506,184				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,390	33,897			6.00
7.00	00700	OPERATION OF PLANT	0	15,765	2,578	115,051		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,043	234	981	6,356	8.00
9.00	00900	HOUSEKEEPING	0	9,374	318	1,333	0	9.00
10.00	01000	DIETARY	0	7,977	732	3,069	1	10.00
11.00	01100	CAFETERIA	0	0	407	1,706	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,475	136	572	0	13.00
15.00	01500	PHARMACY	0	20,658	205	860	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,725	1,279	5,357	0	16.00
17.00	01700	SOCIAL SERVICE	0	770	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	36,855	2,957	12,388	1,877	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	28,048	2,761	11,565	1,273	50.00
53.00	05300	ANESTHESIOLOGY	0	1,017	39	164	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	15,045	552	2,311	195	54.00
54.01	05401	ULTRASOUND	0	6,256	160	668	246	54.01
56.00	05600	RADIOISOTOPE	0	7,185	128	536	0	56.00
57.00	05700	CT SCAN	0	4,549	161	674	243	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,727	412	1,728	178	58.00
60.00	06000	LABORATORY	0	36,556	800	3,350	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,846	81	341	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,556	2,806	11,753	349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,347	77	324	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,756	254	1,063	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,442	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	2,742	252	1,058	0	75.01
75.02	03952	WOUND CENTER	0	3,490	660	2,765	0	75.02
76.00	03953	CARDIAC REHAB	0	3,046	400	1,674	0	76.00
76.01	03030	DIABETES EDUCATION	0	1,328	84	352	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	171,387	7,525	15,366	0	88.00
91.00	09100	EMERGENCY	0	37,881	1,325	5,553	1,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	22,324	729	3,056	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	494,560	28,052	90,567	5,826	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	284	89	372	0	190.00
194.00	07950	FREESTANDING CLINICS	0	8,677	3,271	13,703	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	2,663	2,485	10,409	530	194.01
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)	0	506,184	33,897	115,051	6,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

Period:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	19,095					9.00
10.00	01000	DIETARY	44	30,657				10.00
11.00	01100	CAFETERIA	298	21,926	28,485			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,640	10,292		13.00
15.00	01500	PHARMACY	109	0	1,928	0	32,718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141	0	3,669	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	288	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,496	8,731	2,504	4,067	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,833	0	2,542	3,166	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	368	0	814	0	0	54.00
54.01	05401	ULTRASOUND	244	0	1,177	0	0	54.01
56.00	05600	RADIOISOTOPE	88	0	25	0	0	56.00
57.00	05700	CT SCAN	272	0	301	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	63	0	0	58.00
60.00	06000	LABORATORY	375	0	3,331	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	48	0	1,803	177	0	65.00
66.00	06600	PHYSICAL THERAPY	539	0	3,993	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	32,718	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	104	0	0	0	0	75.01
75.02	03952	WOUND CENTER	269	0	1,765	0	0	75.02
76.00	03953	CARDIAC REHAB	175	0	200	0	0	76.00
76.01	03030	DIABETES EDUCATION	44	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,086	0	551	0	0	88.00
91.00	09100	EMERGENCY	2,270	0	927	2,882	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	106	0	701	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,909	30,657	28,222	10,292	32,718	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	1,033	0	263	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	1,153	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	2,974	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,095	30,657	31,459	10,292	32,718	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,900					16.00
17.00	01700	SOCIAL SERVICE	0	1,058				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,643	1,058		182,578	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,807	0		250,196	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,771	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	986	0		90,944	0	54.00
54.01	05401	ULTRASOUND	407	0		70,025	0	54.01
56.00	05600	RADIOISOTOPE	450	0		10,651	0	56.00
57.00	05700	CT SCAN	150	0		64,506	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	86	0		200,114	0	58.00
60.00	06000	LABORATORY	1,886	0		102,228	0	60.00
65.00	06500	RESPIRATORY THERAPY	536	0		20,516	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		107,229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		5,471	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		8,513	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		6,442	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		32,718	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	471	0		9,280	0	75.01
75.02	03952	WOUND CENTER	236	0		20,732	0	75.02
76.00	03953	CARDIAC REHAB	64	0		17,444	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		3,278	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	26,485	0		426,799	0	88.00
91.00	09100	EMERGENCY	5,657	0		124,477	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0		41,777	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,864	1,058	0	1,798,689	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		14,599	0	190.00
194.00	07950	FREESTANDING CLINICS	2,036	0		98,740	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		53,113	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	2,974	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,900	1,058	0	1,968,115	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
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
13.00	01300	NURSING ADMINISTRATION	13.00
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00	4.00	5A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			1,018,000			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	14,681,006		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,698	5,537	317,189	3,052,144	-6,442,153	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	1,142	212,661	0	6.00
7.00	00700	OPERATION OF PLANT	5,801	756	46,915	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	2,432	200,426	0	9.00
10.00	01000	DIETARY	1,648	0	6,046	194,250	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	31,895	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	82	205,656	0	13.00
15.00	01500	PHARMACY	462	0	451	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	5,252	297,273	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17,241	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,653	0	36,190	1,120,415	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,211	0	95,796	558,696	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	841	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	61,287	377,991	0	54.00
54.01	05401	ULTRASOUND	359	0	58,327	124,935	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	4,577	0	56.00
57.00	05700	CT SCAN	362	0	55,580	36,098	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	184,499	21,364	0	58.00
60.00	06000	LABORATORY	1,799	0	26,071	556,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	183	0	816	49,348	0	65.00
66.00	06600	PHYSICAL THERAPY	481	5,831	26,186	675,397	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	174	0	2,380	44,316	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	568	0	237	0	0	75.01
75.02	03952	WOUND CENTER	1,485	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	899	0	4,916	103,303	0	76.00
76.01	03030	DIABETES EDUCATION	189	0	0	46,728	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	22,303	5,148,174	0	88.00
91.00	09100	EMERGENCY	2,982	0	36,010	762,251	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,641	0	2,110	686,446	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,107	21,753	993,058	14,496,237	-6,410,258	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	12,352	0	0	190.00
194.00	07950	FREESTANDING CLINICS	7,359	0	12,590	119,430	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	5,590	0	65,339	0	194.01
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)	549,473	175,470	1,013,615	4,106,398		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.775635	6.417365	0.995693	0.279708		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,677,462				5.00
6.00	00600	MAINTENANCE & REPAIRS	311,522	76,263			6.00
7.00	00700	OPERATION OF PLANT	768,588	5,801	61,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,869	527	527	10,759	8.00
9.00	00900	HOUSEKEEPING	456,987	716	716	0	9.00
10.00	01000	DIETARY	388,916	1,648	1,648	2	10.00
11.00	01100	CAFETERIA	0	916	916	0	11.00
13.00	01300	NURSING ADMINISTRATION	266,932	307	307	0	13.00
15.00	01500	PHARMACY	1,007,122	462	462	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	474,102	2,877	2,877	0	16.00
17.00	01700	SOCIAL SERVICE	37,521	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,796,759	6,653	6,653	3,176	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,367,384	6,211	6,211	2,155	50.00
53.00	05300	ANESTHESIOLOGY	49,604	88	88	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	733,456	1,241	1,241	330	54.00
54.01	05401	ULTRASOUND	305,002	359	359	417	54.01
56.00	05600	RADIOISOTOPE	350,298	288	288	0	56.00
57.00	05700	CT SCAN	221,768	362	362	411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,968	928	928	301	58.00
60.00	06000	LABORATORY	1,782,189	1,799	1,799	0	60.00
65.00	06500	RESPIRATORY THERAPY	90,008	183	183	0	65.00
66.00	06600	PHYSICAL THERAPY	1,002,122	6,312	6,312	591	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	65,692	174	174	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	134,368	571	571	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	314,069	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	75.00
75.01	03951	SLEEP LAB	133,670	568	568	0	75.01
75.02	03952	WOUND CENTER	170,122	1,485	1,485	0	75.02
76.00	03953	CARDIAC REHAB	148,509	899	899	0	76.00
76.01	03030	DIABETES EDUCATION	64,733	189	189	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,355,389	16,927	8,252	0	88.00
91.00	09100	EMERGENCY	1,846,762	2,982	2,982	2,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,088,320	1,641	1,641	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,110,751	63,114	48,638	9,862	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,854	200	200	0	190.00
194.00	07950	FREESTANDING CLINICS	423,008	7,359	7,359	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	129,849	5,590	5,590	897	194.01
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)	6,442,153	392,846	999,113	75,386	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.261054	5.151200	16.170279	7.006785	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	506,184	33,897	115,051	6,356	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020512	0.444475	1.862058	0.590761	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: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	27,326					10.00
11.00	01100	CAFETERIA	19,544	2,275				11.00
13.00	01300	NURSING ADMINISTRATION	0	131	108,439			13.00
15.00	01500	PHARMACY	0	154	0	1,903,194		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	293	0	0	2,142	16.00
17.00	01700	SOCIAL SERVICE	0	23	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,782	200	42,861	0	170	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	203	33,353	0	131	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	65	0	0	46	54.00
54.01	05401	ULTRASOUND	0	94	0	0	19	54.01
56.00	05600	RADIOISOTOPE	0	2	0	0	21	56.00
57.00	05700	CT SCAN	0	24	0	0	7	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5	0	0	4	58.00
60.00	06000	LABORATORY	0	266	0	0	88	60.00
65.00	06500	RESPIRATORY THERAPY	0	144	1,862	0	25	65.00
66.00	06600	PHYSICAL THERAPY	0	319	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,903,194	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	22	75.01
75.02	03952	WOUND CENTER	0	141	0	0	11	75.02
76.00	03953	CARDIAC REHAB	0	16	0	0	3	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	44	0	0	1,236	88.00
91.00	09100	EMERGENCY	0	74	30,363	0	264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	56	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,326	2,254	108,439	1,903,194	2,047	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	21	0	0	95	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	0	0	194.01
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)	526,954	373,740	364,682	1,308,566	711,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.283979	164.281319	3.363015	0.687563	332.269841	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,657	31,459	10,292	32,718	45,900	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.121899	12.520879	0.094911	0.017191	21.428571	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: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		1.01
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
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	952	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	952	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	75.00
75.01	03951	SLEEP LAB	0	75.01
75.02	03952	WOUND CENTER	0	75.02
76.00	03953	CARDIAC REHAB	0	76.00
76.01	03030	DIABETES EDUCATION	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	952	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
194.00	07950	FREESTANDING CLINICS	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	194.01
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)	51,094	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.670168	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,058	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.111345	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

		Title XVIII		Hospital		Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,941,899		2,941,899	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,148,673		2,148,673	0	0 50.00
53.00	05300 ANESTHESIOLOGY	64,429		64,429	0	0 53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	991,049		991,049	0	0 54.00
54.01	05401 ULTRASOUND	424,512		424,512	0	0 54.01
56.00	05600 RADIOISOTOPE	457,924		457,924	0	0 56.00
57.00	05700 CT SCAN	304,968		304,968	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	437,630		437,630	0	0 58.00
60.00	06000 LABORATORY	2,370,337		2,370,337	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	157,107	0	157,107	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,471,551	0	1,471,551	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	86,551		86,551	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	181,619		181,619	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	396,058		396,058	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,308,566		1,308,566	0	0 73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 75.00
75.01	03951 SLEEP LAB	191,194		191,194	0	0 75.01
75.02	03952 WOUND CENTER	281,338		281,338	0	0 75.02
76.00	03953 CARDIAC REHAB	215,505		215,505	0	0 76.00
76.01	03030 DIABETES EDUCATION	87,020		87,020	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	11,363,722		11,363,722	0	0 88.00
91.00	09100 EMERGENCY	2,682,134		2,682,134	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	542,273		542,273	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,419,898		1,419,898		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	30,525,957	0	30,525,957	0	0 200.00
201.00	Less Observation Beds	542,273		542,273		0 201.00
202.00	Total (see instructions)	29,983,684	0	29,983,684	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,462,866		1,462,866		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	394,286	5,521,852	5,916,138	0.363188	50.00
53.00	05300	ANESTHESIOLOGY	23,706	138,504	162,210	0.397195	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	102,115	3,324,766	3,426,881	0.289199	54.00
54.01	05401	ULTRASOUND	133,009	4,308,935	4,441,944	0.095569	54.01
56.00	05600	RADIOISOTOPE	39,777	1,937,044	1,976,821	0.231647	56.00
57.00	05700	CT SCAN	174,237	14,065,961	14,240,198	0.021416	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	29,291	2,881,896	2,911,187	0.150327	58.00
60.00	06000	LABORATORY	868,331	13,912,170	14,780,501	0.160369	60.00
65.00	06500	RESPIRATORY THERAPY	44,313	358,603	402,916	0.389925	65.00
66.00	06600	PHYSICAL THERAPY	621,311	5,205,567	5,826,878	0.252545	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	33,300	650,799	684,099	0.126518	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,371	1,000,143	1,178,514	0.154108	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	207,728	412,195	619,923	0.638883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,789	2,515,226	2,855,015	0.458339	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	75.00
75.01	03951	SLEEP LAB	2,129	737,780	739,909	0.258402	75.01
75.02	03952	WOUND CENTER	0	547,679	547,679	0.513691	75.02
76.00	03953	CARDIAC REHAB	0	354,086	354,086	0.608623	76.00
76.01	03030	DIABETES EDUCATION	0	36,452	36,452	2.387249	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	7,757,840	7,757,840		88.00
91.00	09100	EMERGENCY	45,848	6,860,834	6,906,682	0.388339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,600	287,204	290,804	1.864737	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,440,215	2,440,215		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,704,007	75,255,751	79,959,758		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,704,007	75,255,751	79,959,758		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

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

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000			75.00
75.01	03951	SLEEP LAB	0.000000			75.01
75.02	03952	WOUND CENTER	0.000000			75.02
76.00	03953	CARDIAC REHAB	0.000000			76.00
76.01	03030	DIABETES EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/1/2019 1:13 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)	Hospital Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	250,196	5,916,138	0.042290	286,547	12,118	50.00
53.00	05300 ANESTHESIOLOGY	2,771	162,210	0.017083	16,779	287	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	90,944	3,426,881	0.026538	61,728	1,638	54.00
54.01	05401 ULTRASOUND	70,025	4,441,944	0.015764	92,001	1,450	54.01
56.00	05600 RADIOISOTOPE	10,651	1,976,821	0.005388	23,953	129	56.00
57.00	05700 CT SCAN	64,506	14,240,198	0.004530	101,172	458	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	200,114	2,911,187	0.068740	21,052	1,447	58.00
60.00	06000 LABORATORY	102,228	14,780,501	0.006916	468,701	3,242	60.00
65.00	06500 RESPIRATORY THERAPY	20,516	402,916	0.050919	22,461	1,144	65.00
66.00	06600 PHYSICAL THERAPY	107,229	5,826,878	0.018402	102,117	1,879	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	5,471	684,099	0.007997	20,340	163	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,513	1,178,514	0.007224	87,972	636	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,442	619,923	0.010392	173,544	1,803	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32,718	2,855,015	0.011460	130,010	1,490	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	9,280	739,909	0.012542	1,806	23	75.01
75.02	03952 WOUND CENTER	20,732	547,679	0.037854	0	0	75.02
76.00	03953 CARDIAC REHAB	17,444	354,086	0.049265	0	0	76.00
76.01	03030 DIABETES EDUCATION	3,278	36,452	0.089926	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	426,799	7,757,840	0.055015	0	0	88.00
91.00	09100 EMERGENCY	124,477	6,906,682	0.018023	2,661	48	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,654	290,804	0.115727	800	93	92.00
200.00	Total (lines 50 through 199)	1,607,988	76,056,677		1,613,644	28,048	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/1/2019 1:13 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/1/2019 1:13 pm

				Title XVIII		Hospital	Cost		
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,916,138	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	162,210	0.000000	53.00	
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	3,426,881	0.000000	54.00	
54.01	05401	ULTRASOUND	0	0	0	4,441,944	0.000000	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	1,976,821	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	14,240,198	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,911,187	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	14,780,501	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	402,916	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	5,826,878	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	684,099	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,178,514	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	619,923	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,855,015	0.000000	73.00	
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	75.00	
75.01	03951	SLEEP LAB	0	0	0	739,909	0.000000	75.01	
75.02	03952	WOUND CENTER	0	0	0	547,679	0.000000	75.02	
76.00	03953	CARDIAC REHAB	0	0	0	354,086	0.000000	76.00	
76.01	03030	DIABETES EDUCATION	0	0	0	36,452	0.000000	76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,757,840	0.000000	88.00	
91.00	09100	EMERGENCY	0	0	0	6,906,682	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	290,804	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	76,056,677		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	286,547	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,779	0	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	61,728	0	0	0 54.00
54.01	05401	ULTRASOUND	0.000000	92,001	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	23,953	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	101,172	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	21,052	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	468,701	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	22,461	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	102,117	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,340	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	87,972	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	173,544	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	130,010	0	0	0 73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0.000000	1,806	0	0	0 75.01
75.02	03952	WOUND CENTER	0.000000	0	0	0	0 75.02
76.00	03953	CARDIAC REHAB	0.000000	0	0	0	0 76.00
76.01	03030	DIABETES EDUCATION	0.000000	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	2,661	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	800	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,613,644	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/1/2019 1:13 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.363188	0	2,112,821	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.397195	0	42,084	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.289199	0	943,760	0	0	54.00
54.01	05401	ULTRASOUND	0.095569	0	1,751,012	0	0	54.01
56.00	05600	RADIOISOTOPE	0.231647	0	898,168	0	0	56.00
57.00	05700	CT SCAN	0.021416	0	5,518,332	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.150327	0	1,005,462	0	0	58.00
60.00	06000	LABORATORY	0.160369	0	5,225,693	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389925	0	167,671	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.252545	0	1,867,140	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.126518	0	287,684	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154108	0	311,259	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.638883	0	158,882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458339	0	1,966,710	111	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.258402	0	249,800	0	0	75.01
75.02	03952	WOUND CENTER	0.513691	0	299,292	0	0	75.02
76.00	03953	CARDIAC REHAB	0.608623	0	165,800	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.387249	0	3,260	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.388339	0	1,799,638	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.864737	0	155,184	0	0	92.00
200.00		Subtotal (see instructions)		0	24,929,652	111	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	24,929,652	111	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1349		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/1/2019 1:13 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	767,351	0				50.00	
53.00	05300	ANESTHESIOLOGY	16,716	0				53.00	
54.00	05400	RADIOLOGY - DIAGNOSTIC	272,934	0				54.00	
54.01	05401	ULTRASOUND	167,342	0				54.01	
56.00	05600	RADIOISOTOPE	208,058	0				56.00	
57.00	05700	CT SCAN	118,181	0				57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	151,148	0				58.00	
60.00	06000	LABORATORY	838,039	0				60.00	
65.00	06500	RESPIRATORY THERAPY	65,379	0				65.00	
66.00	06600	PHYSICAL THERAPY	471,537	0				66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0				67.00	
68.00	06800	SPEECH PATHOLOGY	0	0				68.00	
69.00	06900	ELECTROCARDIOLOGY	36,397	0				69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,968	0				71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	101,507	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	901,420	51				73.00	
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0				75.00	
75.01	03951	SLEEP LAB	64,549	0				75.01	
75.02	03952	WOUND CENTER	153,744	0				75.02	
76.00	03953	CARDIAC REHAB	100,910	0				76.00	
76.01	03030	DIABETES EDUCATION	7,782	0				76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00	
91.00	09100	EMERGENCY	698,870	0				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	289,377	0				92.00	
200.00		Subtotal (see instructions)	5,479,209	51				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	5,479,209	51				202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period:

Worksheet D

Component CCN: 14-Z349

From 07/01/2018

Part V

To 06/30/2019

Date/Time Prepared:

11/1/2019 1:13 pm

			Title XVIII	Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.363188	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.397195	0	0	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.289199	0	0	0	0
54.01	05401	ULTRASOUND	0.095569	0	0	0	0
56.00	05600	RADIOISOTOPE	0.231647	0	0	0	0
57.00	05700	CT SCAN	0.021416	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.150327	0	0	0	0
60.00	06000	LABORATORY	0.160369	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.389925	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.252545	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.126518	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154108	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.638883	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458339	0	0	0	0
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
75.01	03951	SLEEP LAB	0.258402	0	0	0	0
75.02	03952	WOUND CENTER	0.513691	0	0	0	0
76.00	03953	CARDIAC REHAB	0.608623	0	0	0	0
76.01	03030	DIABETES EDUCATION	2.387249	0	0	0	0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0
91.00	09100	EMERGENCY	0.388339	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.864737	0	0	0	0
200.00		Subtotal (see instructions)		0	0	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1349

Period:

Worksheet D

Component CCN:14-Z349

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/1/2019 1:13 pm

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/1/2019 1:13 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,356	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)		952	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		832	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		17	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)		16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		641	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)		709	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		152.66	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		152.66	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,941,899	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)		2,595	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)		2,443	25.00
26.00	Total swing-bed cost (see instructions)		1,121,798	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,820,101	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,820,101	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,342.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		860,389	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)		860,389	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					447,557	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,307,946	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)					951,662	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					951,662	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)					404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,342.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					542,273	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/1/2019 1:13 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	182,578	2,941,899	0.062061	542,273	33,654
91.00	Nursing School cost	0	2,941,899	0.000000	542,273	0
92.00	Allied health cost	0	2,941,899	0.000000	542,273	0
93.00	All other Medical Education	0	2,941,899	0.000000	542,273	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/1/2019 1:13 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		424,800		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.363188	286,547	104,070	50.00
53.00	05300 ANESTHESIOLOGY	0.397195	16,779	6,665	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.289199	61,728	17,852	54.00
54.01	05401 ULTRASOUND	0.095569	92,001	8,792	54.01
56.00	05600 RADIOISOTOPE	0.231647	23,953	5,549	56.00
57.00	05700 CT SCAN	0.021416	101,172	2,167	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.150327	21,052	3,165	58.00
60.00	06000 LABORATORY	0.160369	468,701	75,165	60.00
65.00	06500 RESPIRATORY THERAPY	0.389925	22,461	8,758	65.00
66.00	06600 PHYSICAL THERAPY	0.252545	102,117	25,789	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.126518	20,340	2,573	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154108	87,972	13,557	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.638883	173,544	110,874	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.458339	130,010	59,589	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.258402	1,806	467	75.01
75.02	03952 WOUND CENTER	0.513691	0	0	75.02
76.00	03953 CARDIAC REHAB	0.608623	0	0	76.00
76.01	03030 DIABETES EDUCATION	2.387249	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.388339	2,661	1,033	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.864737	800	1,492	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,613,644	447,557	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)		1,613,644		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349 Component CCN: 14-Z349	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/1/2019 1:13 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.363188	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.397195	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.289199	12,498	3,614	54.00
54.01	05401 ULTRASOUND	0.095569	5,079	485	54.01
56.00	05600 RADIOISOTOPE	0.231647	4,742	1,098	56.00
57.00	05700 CT SCAN	0.021416	24,251	519	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.150327	0	0	58.00
60.00	06000 LABORATORY	0.160369	163,555	26,229	60.00
65.00	06500 RESPIRATORY THERAPY	0.389925	10,275	4,006	65.00
66.00	06600 PHYSICAL THERAPY	0.252545	394,328	99,586	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.126518	5,400	683	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.154108	8,958	1,380	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.638883	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.458339	102,645	47,046	73.00
75.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.258402	323	83	75.01
75.02	03952 WOUND CENTER	0.513691	0	0	75.02
76.00	03953 CARDIAC REHAB	0.608623	0	0	76.00
76.01	03030 DIABETES EDUCATION	2.387249	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100 EMERGENCY	0.388339	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.864737	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		732,054	184,729	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)		732,054		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/1/2019 1:13 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,479,260	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs 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)		5,479,260	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)		5,534,053	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)		47,148	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,904,567	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,582,338	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,582,338	30.00
31.00	Primary payer payments		1,299	31.00
32.00	Subtotal (line 30 minus line 31)		1,581,039	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)		1,005,333	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		653,466	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		506,794	36.00
37.00	Subtotal (see instructions)		2,234,505	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)		2,234,505	40.00
40.01	Sequestration adjustment (see instructions)		44,690	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,396,527	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-206,712	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: 14-1349

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

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		972,992		2,414,415	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	12/05/2018	9,236	12/05/2018	17,888	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)		-9,236		-17,888	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)		963,756		2,396,527	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		169,453		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		206,712	6.02
7.00	Total Medicare program liability (see instructions)		1,133,209		2,189,815	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: 14-1349

Period:

Worksheet E-1

Component CCN: 14-Z349

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/1/2019 1:13 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,063,739		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/05/2018	19,239		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19,239		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,082,978		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		33,177		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,116,155		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: 14-1349

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1349

Period:

Worksheet E-2

Component CCN:14-Z349

From 07/01/2018

Date/Time Prepared:

To 06/30/2019

11/1/2019 1:13 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		961,179	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)		186,576	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		709	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,147,755	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,147,755	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,147,755	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		9,135	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,138,620	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)		483	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		314	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,138,934	0	19.00
19.01	Sequestration adjustment (see instructions)		22,779	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,082,978	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)		33,177	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:14-1349	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/1/2019 1:13 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,307,946	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)		1,307,946	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,321,025	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)		1,321,025	19.00
20.00	Deductibles (exclude professional component)		224,577	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,096,448	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,096,448	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		92,136	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		59,888	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		35,709	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,156,336	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)		1,156,336	30.00
30.01	Sequestration adjustment (see instructions)		23,127	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		963,756	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)		169,453	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1349

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

Worksheet G

Date/Time Prepared:
11/1/2019 1:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	15,365,626	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	18,535,505	0	0	0	4.00
5.00	Other receivable	624,508	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,150,782	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,367,831	0	0	0	8.00
9.00	Other current assets	594,109	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)	24,336,797	0	0	0	11.00
FIXED ASSETS						
12.00	Land	356,334	0	0	0	12.00
13.00	Land improvements	838,535	0	0	0	13.00
14.00	Accumulated depreciation	-695,330	0	0	0	14.00
15.00	Buildings	17,065,817	0	0	0	15.00
16.00	Accumulated depreciation	-13,043,732	0	0	0	16.00
17.00	Leasehold improvements	33,261	0	0	0	17.00
18.00	Accumulated depreciation	-22,720	0	0	0	18.00
19.00	Fixed equipment	23,015	0	0	0	19.00
20.00	Accumulated depreciation	-22,652	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	13,485,841	0	0	0	23.00
24.00	Accumulated depreciation	-10,634,171	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	110,789	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,494,987	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,370,396	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,370,396	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,202,180	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	819,075	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,256,438	0	0	0	38.00
39.00	Payroll taxes payable	1,924,971	0	0	0	39.00
40.00	Notes and loans payable (short term)	484,287	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,484,771	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,353,530	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)	1,353,530	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,838,301	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	28,363,879				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)	28,363,879	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,202,180	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1349

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

Worksheet G-1

Date/Time Prepared:
11/1/2019 1:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		25,430,839		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,933,040				2.00
3.00	Total (sum of line 1 and line 2)		28,363,879		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)		28,363,879		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)		28,363,879		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: 14-1349

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/1/2019 1:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,317,905		1,317,905	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	143,470		143,470	5.00
6.00	Swing bed - NF	5,691		5,691	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)	1,467,066		1,467,066	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)	1,467,066		1,467,066	17.00
18.00	Ancillary services	3,205,961	59,138,317	62,344,278	18.00
19.00	Outpatient services	49,448	7,228,268	7,277,716	19.00
20.00	RURAL HEALTH CLINIC	0	8,136,972	8,136,972	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,440,215	2,440,215	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	PROFESSIONAL FEES	75,611	1,454,276	1,529,887	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,798,086	78,398,048	83,196,134	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,596,786		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)		35,596,786		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1349

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

Worksheet G-3

Date/Time Prepared:
11/1/2019 1:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	83,196,134	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,647,033	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,549,101	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,596,786	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,047,685	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	91,965	6.00
7.00	Income from investments	355,861	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	39,017	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	365	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	200,998	22.00
23.00	Governmental appropriations	255,284	23.00
24.00	OTHER MISC REVENUE	706,959	24.00
24.01	340B CONTRACT PHARMACY REVENUE	2,330,276	24.01
25.00	Total other income (sum of lines 6-24)	3,980,725	25.00
26.00	Total (line 5 plus line 25)	2,933,040	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)	2,933,040	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2018 To 06/30/2019	Worksheet H Date/Time Prepared: 11/1/2019 1:13 pm
						Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportatio n (see instructions)	Contracted/Pu rchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	22,477	22,477	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	294,372	0	0	170,620	464,992	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	256,637	0	0	0	256,637	6.00
7.00	Physical Therapy	164,405	0	0	0	164,405	7.00
8.00	Occupational Therapy	0	0	0	1,208	1,208	8.00
9.00	Speech Pathology	0	0	0	12,247	12,247	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	193	0	0	0	193	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	715,607	0	0	13,455	922,159	24.00
	Reclassificat ion	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	-7,049	15,428	0	15,428		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-33,655	431,337	0	431,337		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	256,637	0	256,637		6.00
7.00	Physical Therapy	0	164,405	0	164,405		7.00
8.00	Occupational Therapy	0	1,208	0	1,208		8.00
9.00	Speech Pathology	0	12,247	0	12,247		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	193	0	193		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-40,704	881,455	0	881,455		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n		
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	15,428	0	0	15,428		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	431,337	0	0	15,428	0	446,765	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	256,637	0	0	0	0	256,637	6.00
7.00	Physical Therapy	164,405	0	0	0	0	164,405	7.00
8.00	Occupational Therapy	1,208	0	0	0	0	1,208	8.00
9.00	Speech Pathology	12,247	0	0	0	0	12,247	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	193	0	0	0	0	193	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	881,455	0	0	15,428	0	881,455	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	446,765						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	263,766	520,403					6.00
7.00	Physical Therapy	168,972	333,377					7.00
8.00	Occupational Therapy	1,242	2,450					8.00
9.00	Speech Pathology	12,587	24,834					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	198	391					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		881,455					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	1,641	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	1,641	0	-446,765	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	256,637	6.00
7.00	Physical Therapy	0	0	0	0	164,405	7.00
8.00	Occupational Therapy	0	0	0	0	1,208	8.00
9.00	Speech Pathology	0	0	0	0	12,247	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	193	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-446,765	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	15,428	0	446,765	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	9.401584	0.000000	1.027778	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	12,760	0	2,101	74,182	89,043	1.00
2.00	Skilled Nursing Care	520,403	0	0	0	71,783	592,186	2.00
3.00	Physical Therapy	333,377	0	0	0	45,985	379,362	3.00
4.00	Occupational Therapy	2,450	0	0	0	0	2,450	4.00
5.00	Speech Pathology	24,834	0	0	0	0	24,834	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	391	0	0	0	54	445	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	881,455	12,760	0	2,101	192,004	1,088,320	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	23,245	8,453	26,535	0	3,280	0	1.00
2.00	Skilled Nursing Care	154,592	0	0	0	0	0	2.00
3.00	Physical Therapy	99,034	0	0	0	0	0	3.00
4.00	Occupational Therapy	640	0	0	0	0	0	4.00
5.00	Speech Pathology	6,483	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	116	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	284,110	8,453	26,535	0	3,280	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	9,200	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	9,200	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	159,756	0	159,756				1.00
2.00	Skilled Nursing Care	746,778	0	746,778	94,674	841,452		2.00
3.00	Physical Therapy	478,396	0	478,396	60,649	539,045		3.00
4.00	Occupational Therapy	3,090	0	3,090	392	3,482		4.00
5.00	Speech Pathology	31,317	0	31,317	3,970	35,287		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	561	0	561	71	632		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,419,898	0	1,419,898	159,756	1,419,898		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.126776			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00				
1.00	Administrative and General	1,641	0	2,110	265,211	0	89,043	1.00
2.00	Skilled Nursing Care	0	0	0	256,637	0	592,186	2.00
3.00	Physical Therapy	0	0	0	164,405	0	379,362	3.00
4.00	Occupational Therapy	0	0	0	0	0	2,450	4.00
5.00	Speech Pathology	0	0	0	0	0	24,834	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	193	0	445	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	0	2,110	686,446		1,088,320	20.00
21.00	Total cost to be allocated	12,760	0	2,101	192,004		284,110	21.00
22.00	Unit cost multiplier	7.775746	0.000000	0.995735	0.279707		0.261054	22.00
Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	1,641	0	1,135	0	56	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	1,641	0	1,135	0	56	20.00
21.00	Total cost to be allocated	8,453	26,535	0	3,280	0	9,200	21.00
22.00	Unit cost multiplier	5.151127	16.170018	0.000000	2.889868	0.000000	164.285714	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

HHA CCN: 14-7694

Period:

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

Worksheet H-2

Part II

Date/Time Prepared:
11/1/2019 1:13 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	15.00	16.00	17.00	19.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/1/2019 1:13 pm

				Title XVIII		Home Health Agency I		PPS	
Cost Center Description			From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care		2.00	841,452		841,452	4,607	182.65	1.00
2.00	Physical Therapy		3.00	539,045	0	539,045	3,934	137.02	2.00
3.00	Occupational Therapy		4.00	3,482	0	3,482	443	7.86	3.00
4.00	Speech Pathology		5.00	35,287	0	35,287	117	301.60	4.00
5.00	Medical Social Services		6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide		7.00	632	0	632	0	0.00	6.00
7.00	Total (sum of lines 1-6)			1,419,898	0	1,419,898	9,101		7.00
			Program Visits						
					Part B				
					Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
			0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation									
8.00	Skilled Nursing Care			16060	0	108			8.00
8.01	Skilled Nursing Care			41180	0	199			8.01
8.02	Skilled Nursing Care			99914	0	1,818			8.02
9.00	Physical Therapy			16060	0	140			9.00
9.01	Physical Therapy			41180	0	162			9.01
9.02	Physical Therapy			99914	0	1,897			9.02
10.00	Occupational Therapy			16060	0	12			10.00
10.01	Occupational Therapy			41180	0	12			10.01
10.02	Occupational Therapy			99914	0	183			10.02
11.00	Speech Pathology			16060	0	0			11.00
11.01	Speech Pathology			41180	0	19			11.01
11.02	Speech Pathology			99914	0	36			11.02
12.00	Medical Social Services			16060	0	0			12.00
12.01	Medical Social Services			41180	0	0			12.01
12.02	Medical Social Services			99914	0	0			12.02
13.00	Home Health Aide			16060	0	0			13.00
13.01	Home Health Aide			41180	0	0			13.01
13.02	Home Health Aide			99914	0	0			13.02
14.00	Total (sum of lines 8-13)				0	4,586			14.00
			Cost Center Description						
			From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies		8.00	0	2,640	2,640	0	0.000000	15.00
16.00	Cost of Drugs		9.00	0	0	0	0	0.000000	16.00
			Program Visits				Cost of Services		
					Part B				
					Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
			6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care		0	2,125		0	388,131		1.00
2.00	Physical Therapy		0	2,199		0	301,307		2.00
3.00	Occupational Therapy		0	207		0	1,627		3.00
4.00	Speech Pathology		0	55		0	16,588		4.00
5.00	Medical Social Services		0	0		0	0		5.00
6.00	Home Health Aide		0	0		0	0		6.00
7.00	Total (sum of lines 1-6)		0	4,586		0	707,653		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/1/2019 1:13 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00		10.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	14,533	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	388,131						1.00	
2.00	Physical Therapy	301,307						2.00	
3.00	Occupational Therapy	1,627						3.00	
4.00	Speech Pathology	16,588						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	0						6.00	
7.00	Total (sum of lines 1-6)	707,653						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2018

Part II

To 06/30/2019

Date/Time Prepared:

11/1/2019 1:13 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.252545	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.154108	17,133	2,640	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.458339	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2018 To 06/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 11/1/2019 1:13 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	828,589
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	14,584
13.00	Total PPS Reimbursement - LUPA Episodes		0	5,485
14.00	Total PPS Reimbursement - PEP Episodes		0	13,555
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	1,132
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	296
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	863,641
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	863,641
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	863,641
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	863,641
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	863,641
31.01	Sequestration adjustment (see instructions)		0	17,272
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	846,369
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1349 HHA CCN: 14-7694		Period: From 07/01/2018 To 06/30/2019		Worksheet H-5 Date/Time Prepared: 11/1/2019 1:13 pm	
				Home Health Agency I		PPS	
		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		0		846,369	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			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			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)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		846,369	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		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			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		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		846,369	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/1/2019 1:13 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,565,458	755,417	3,320,875	-194,882	3,125,993
2.00	Physician Assistant	332,656	0	332,656	7,478	340,134
3.00	Nurse Practitioner	554,964	0	554,964	0	554,964
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,236,848	0	1,236,848	0	1,236,848
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	26,112	26,112	-7,478	18,634
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	4,689,926	781,529	5,471,455	-194,882	5,276,573
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	511,792	511,792	0	511,792
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	158,675	158,675	0	158,675
19.00	Other Health Care Costs	0	37,356	37,356	0	37,356
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	707,823	707,823	0	707,823
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,689,926	1,489,352	6,179,278	-194,882	5,984,396
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	48,185	0	48,185	0	48,185
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	48,185	0	48,185	0	48,185
FACILITY OVERHEAD						
29.00	Facility Costs	0	85,608	85,608	-20,491	65,117
30.00	Administrative Costs	445,063	176,981	622,044	23,414	645,458
31.00	Total Facility Overhead (sum of lines 29 and 30)	445,063	262,589	707,652	2,923	710,575
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,183,174	1,751,941	6,935,115	-191,959	6,743,156

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2018

To 06/30/2019

Date/Time Prepared:
11/1/2019 1:13 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	3,125,993	1.00
2.00	Physician Assistant	-12,400	327,734	2.00
3.00	Nurse Practitioner	0	554,964	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,236,848	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	18,634	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-12,400	5,264,173	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	511,792	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	158,675	18.00
19.00	Other Health Care Costs	0	37,356	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	707,823	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-12,400	5,971,996	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	48,185	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	48,185	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	65,117	29.00
30.00	Administrative Costs	0	645,458	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	710,575	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-12,400	6,730,756	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1349

Period:

Worksheet M-2

Component CCN: 14-3464

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/1/2019 1:13 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	7.92	25,588	4,200	33,264	1.00
2.00	Physician Assistant	2.54	8,139	2,100	5,334	2.00
3.00	Nurse Practitioner	4.77	13,523	2,100	10,017	3.00
4.00	Subtotal (sum of lines 1 through 3)	15.23	47,250		48,615	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	0.17	166		166	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)	15.40	47,416		48,781	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)				5,971,996	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				48,185	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				6,020,181	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.991996	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				710,575	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				4,632,966	15.00
16.00	Total overhead (sum of lines 14 and 15)				5,343,541	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				5,343,541	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				5,300,771	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				11,272,767	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1349 Component CCN:14-3464	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/1/2019 1:13 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			11,272,767	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			333,402	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			10,939,365	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			48,781	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)			48,781	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			224.25	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)			224.25	224.25	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	13,440	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	3,013,920	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	3,013,920	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,859,594	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				99,503	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				161,269	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.)				2,158,782	16.04
16.05	Total program cost (see instructions)			0	2,320,051	16.05
17.00	Primary payer amounts				18	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				154,174	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				321,183	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				2,320,033	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				137,401	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				2,457,434	22.00
23.00	Allowable bad debts (see instructions)				111,840	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				72,696	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				76,020	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)				2,530,130	26.00
26.01	Sequestration adjustment (see instructions)				50,603	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				2,139,473	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)				340,054	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: 14-1349 Component CCN: 14-3464	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/1/2019 1:13 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		5,264,173	5,264,173	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000557	0.002095	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,932	11,028	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		96,013	66,654	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		98,945	77,682	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		5,971,996	5,971,996	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,300,771	5,300,771	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.016568	0.013008	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		87,823	68,952	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		186,768	146,634	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		620	2,333	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		301.24	62.85	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		289	801	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		87,058	50,343	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)			333,402	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)			137,401	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/1/2019 1:13 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,080,718	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		12/05/2018	58,755	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		58,755	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,139,473	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		340,054	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,479,527	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00