

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/12/2020 2:36 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 6/12/2020	Time: 2:36 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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	24,844	386,528	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	-25,286	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		18,586		0	10.00
200.00	Total	0	-442	405,114	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: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/12/2020 2:36 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: SOUTH ADAMS STREET			PO Box: 160				1.00	
2.00	City: CARTHAGE			State: IL		Zip Code: 62321-		County: HANCOCK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O
4.00	Subprovider - IPF								P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O
8.00	Swing Beds - NF								N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		BOWEN CLINIC	143456	99914		02/05/1999	N	O
16.00	Hospital-Based Health Clinic - FQHC								N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	
21.00	Type of Control (see instructions)						2		
							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.					2	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1305

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural St	Date of Geogra	
						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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1305

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

MCRIF32 - 15.13.167.1

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		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	198,846	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.	Y		5.01	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		H55770	140.00

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: UNITYPOINT HEALTH (IA HEALTH SYSTEM)	Contractor's Name: WPS		Contractor's Number: 05001		141.00	
142.00	Street: 1776 WEST LAKES PARKWAY SUITE 400	PO Box:				142.00	
143.00	City: WEST DES MOINES	State: IA		Zip Code: 50266-8239		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00
						Beginning	Ending
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/12/2020 2:36 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/02/2020	Y 04/02/2020
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		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?		Y		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.		Y		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.	TERESA	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer	MEMORIAL HOSPITAL ASSOCIATION			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
6/12/2020 2:36 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.	CHIEF FINANCIAL OFFICER	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/12/2020 2:36 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	26,304.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		18	6,570	26,304.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		18	6,570	26,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		18				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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/12/2020 2:36 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)	592	193	1,096			1.00
2.00	HMO and other (see instructions)	88	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	767	0	804			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	7			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,359	193	1,907			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		107	225			13.00
14.00	Total (see instructions)	1,359	300	2,132	0.00	143.00	14.00
15.00	CAH visits	11,372	5,743	28,600			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			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	6,436	8,914	30,647	0.00	51.96	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	194.96	27.00
28.00	Observation Bed Days		66	256			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	34	47			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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/12/2020 2:36 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	180	77	394	1.00
2.00 HMO and other (see instructions)			27	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	180	77	394	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	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MEMORIAL HOSPITAL ASSOCIATION		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1305 Component CCN: 14-3456		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 6/12/2020 2:36 pm		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street					
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	IL				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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC		08:00	17:00	08:00	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	BOWEN CLINIC		143456		14.00
14.01		ADAMS STREET CLINIC		143405		14.01
14.02		LAHARPE CLINIC		148534		14.02
14.03		NAUVOO CLINIC		148547		14.03
14.04		CARTHAGE CLINIC		148571		14.04
14.05		COLCHESTER CLINIC		148572		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

MCRIF32 - 15.13.167.1

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/12/2020 2:36 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)			0.544478 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	3,254,775		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	1,984,469		5.00
6.00	Medicaid charges	11,759,272		6.00
7.00	Medicaid cost (line 1 times line 6)	6,402,665		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,163,421		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	319,275		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,163,421		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)	74,283	322,441	396,724 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	40,445	322,441	362,886 21.00
22.00	Payments received from patients for amounts previously written off as charity care	268	12,475	12,743 22.00
23.00	Cost of charity care (line 21 minus line 22)	40,177	309,966	350,143 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)	1,075,494		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	213,415		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	328,330		27.01
28.00	Non-Medicare bad debt expense (see instructions)	747,164		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	521,729		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	871,872		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,035,293		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,372,920	1,372,920	-1,357,606	15,314	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	1,646,814	1,646,814	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	411,213	411,213	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		845,586	845,586	-59,134	786,452	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	82,991	82,991	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	143,494	2,991,204	3,134,698	-7,119	3,127,579	4.00
5.01	00550	ADMINISTRATION & GENERAL	1,987,239	2,742,675	4,729,914	1,626	4,731,540	5.01
7.00	00700	OPERATION OF PLANT	212,224	537,183	749,407	0	749,407	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE		76,558	76,558	0	76,558	8.00
9.00	00900	HOUSEKEEPING	158,727	41,212	199,939	0	199,939	9.00
10.00	01000	DIETARY	178,915	173,608	352,523	-151,456	201,067	10.00
11.00	01100	CAFETERIA	0	0	0	151,456	151,456	11.00
13.00	01300	NURSING ADMINISTRATION	186,593	56,047	242,640	-81,017	161,623	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,308	13,478	197,786	0	197,786	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	81,017	81,017	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	479,010	29,577	508,587	0	508,587	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,056,938	195,920	1,252,858	341,874	1,594,732	30.00
43.00	04300	NURSERY	0	0	0	297,180	297,180	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	303,801	508,579	812,380	91,606	903,986	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,743	299,616	655,359	-576,409	78,950	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,013	474,636	1,044,649	0	1,044,649	54.00
56.00	05600	RADIOISOTOPE	0	103,788	103,788	0	103,788	56.00
60.00	06000	LABORATORY	732,094	832,501	1,564,595	0	1,564,595	60.00
60.02	06002	GEO PSYCH	147,448	62,578	210,026	0	210,026	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	34,166	34,166	0	34,166	62.00
65.00	06500	RESPIRATORY THERAPY	238,172	61,893	300,065	-78,494	221,571	65.00
66.00	06600	PHYSICAL THERAPY	0	124,406	124,406	0	124,406	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,416	3,416	78,494	81,910	69.00
69.01	06901	PULMONARY REHAB	48,966	2,113	51,079	0	51,079	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,886	21,782	45,668	-32,570	13,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,570	32,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,737	911,105	1,101,842	14,117	1,115,959	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,252,066	1,100,585	5,352,651	-111,987	5,240,664	88.00
90.00	09000	CLINIC	63,044	133,868	196,912	6,770	203,682	90.00
91.00	09100	EMERGENCY	412,428	1,917,064	2,329,492	0	2,329,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	86,744	3,012	89,756	0	89,756	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		781,936	781,936	-781,936	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,012,590	16,453,012	28,465,602	0	28,465,602	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	466,992	142,283	609,275	0	609,275	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	12,479,582	16,595,295	29,074,877	0	29,074,877	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	15,314	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-24,360	1,622,454	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-36,438	374,775	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	786,452	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	82,991	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,479	3,112,100	4.00
5.01	00550	ADMINISTRATION & GENERAL	-73,550	4,657,990	5.01
7.00	00700	OPERATION OF PLANT	0	749,407	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,558	8.00
9.00	00900	HOUSEKEEPING	0	199,939	9.00
10.00	01000	DIETARY	-917	200,150	10.00
11.00	01100	CAFETERIA	-45,063	106,393	11.00
13.00	01300	NURSING ADMINISTRATION	0	161,623	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-331	197,455	16.00
17.00	01700	SOCIAL SERVICE	0	81,017	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	508,587	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-60,285	1,534,447	30.00
43.00	04300	NURSERY	0	297,180	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-311,414	592,572	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,950	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,044,649	54.00
56.00	05600	RADIOISOTOPE	0	103,788	56.00
60.00	06000	LABORATORY	0	1,564,595	60.00
60.02	06002	GEO PSYCH	-42,657	167,369	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	34,166	62.00
65.00	06500	RESPIRATORY THERAPY	0	221,571	65.00
66.00	06600	PHYSICAL THERAPY	-5,058	119,348	66.00
69.00	06900	ELECTROCARDIOLOGY	0	81,910	69.00
69.01	06901	PULMONARY REHAB	0	51,079	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-432,992	682,967	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-30,553	5,210,111	88.00
90.00	09000	CLINIC	-129,122	74,560	90.00
91.00	09100	EMERGENCY	-370,272	1,959,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	89,756	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,578,491	26,887,111	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	609,275	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,578,491	27,496,386	200.00

RECLASSIFICATIONS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
6/12/2020 2:36 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,005,123		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	300,401		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	50,980		3.00
	TOTALS		0	1,356,504		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	76,868	74,588		1.00
	TOTALS		76,868	74,588		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	5,052		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	5,052		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	81,017	0		1.00
	TOTALS		81,017	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27,807		1.00
2.00	ADMINISTRATION & GENERAL	5.01	0	1,626		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	641,691		3.00
4.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	110,812		4.00
	TOTALS		0	781,936		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	155,421	123,808		1.00
2.00	NURSERY	43.00	165,413	131,767		2.00
	TOTALS		320,834	255,575		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	82,991		1.00
	TOTALS		0	82,991		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	64,283	14,211		1.00
	TOTALS		64,283	14,211		
	I - TO RECLASS NON RHC TIME					
1.00	OPERATING ROOM	50.00	88,155	0		1.00
2.00	CLINIC	90.00	19,579	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	60,285	0		3.00
	TOTALS		168,019	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	CLINIC	90.00	0	1,308		1.00
2.00	OPERATING ROOM	50.00	0	3,451		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,360		3.00
	TOTALS		0	7,119		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32,570		1.00
	TOTALS		0	32,570		
	N - DERMATOLOGY DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,117		1.00
	TOTALS		0	14,117		
500.00	Grand Total: Increases		711,021	2,624,663		500.00

RECLASSIFICATIONS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
6/12/2020 2:36 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,356,504	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
	TOTALS		0	1,356,504		
	B - TO RECLASS CAFETERIA					
1.00	DIETARY	10.00	76,868	74,588	0	1.00
	TOTALS		76,868	74,588		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,102	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,950	11	2.00
	TOTALS		0	5,052		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	NURSING ADMINISTRATION	13.00	81,017	0	0	1.00
	TOTALS		81,017	0		
	E - TO RECLASS INTEREST					
1.00	INTEREST EXPENSE	113.00	0	781,936	11	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	781,936		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	155,421	123,808	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	165,413	131,767	0	2.00
	TOTALS		320,834	255,575		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	82,991	9	1.00
	TOTALS		0	82,991		
	H - TO RECLASS EKG TIME					
1.00	RESPIRATORY THERAPY	65.00	64,283	14,211	0	1.00
	TOTALS		64,283	14,211		
	I - TO RECLASS NON RHC TIME					
1.00	RURAL HEALTH CLINIC	88.00	168,019	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		168,019	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,119	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	7,119		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,570	0	1.00
	TOTALS		0	32,570		
	N - DERMATOLOGY DRUGS RECLASS					
1.00	CLINIC	90.00	0	14,117	0	1.00
	TOTALS		0	14,117		
500.00	Grand Total: Decreases		711,021	2,624,663		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
6/12/2020 2:36 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	499,957	0	0	0	0	1.00	
2.00	Land Improvements	1,344,572	0	0	0	14,418	2.00	
3.00	Buildings and Fixtures	25,087,806	31,905	0	31,905	41,843	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	7,823,552	767,816	0	767,816	492,979	6.00	
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	36,724,656	799,721	0	799,721	549,240	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	36,724,656	799,721	0	799,721	549,240	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	499,957	0				1.00	
2.00	Land Improvements	1,330,154	0				2.00	
3.00	Buildings and Fixtures	25,077,868	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,098,389	0				6.00	
7.00	HIT designated Assets	1,968,769	0				7.00	
8.00	Subtotal (sum of lines 1-7)	36,975,137	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	36,975,137	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
6/12/2020 2:36 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	NEW CAP REL COSTS-BLDG & FIXT	1,372,920	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	845,586	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,218,506	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,372,920				1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0				1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	845,586				2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,218,506				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
6/12/2020 2:36 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	NEW CAP REL COSTS-BLDG & FIXT	1,696,718	0	1,696,718	0.045888	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	20,125,770	0	20,125,770	0.544306	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,085,491	0	5,085,491	0.137538	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9,566,427	0	9,566,427	0.258726	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	500,730	0	500,730	0.013542	0	2.01
3.00	Total (sum of lines 1-2)	36,975,136	0	36,975,136	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,314	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	991,103	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	300,401	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	762,595	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	82,991	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,152,404	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	15,314	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	631,351	0	0	0	1,622,454	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	74,374	0	0	0	374,775	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	23,857	0	0	0	786,452	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	82,991	2.01
3.00	Total (sum of lines 1-2)	729,582	0	0	0	2,881,986	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
6/12/2020 2:36 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				3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)			0CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-14,020	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,556	ADMINISTRATION & GENERAL	5.01	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	-929,229			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	758,411			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-45,063	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-331	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-917	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-5,058	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-2,311	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	IT MISC REVENUE	B	0	ADMINISTRATION & GENERAL	5.01	0	35.00
36.00	LOBBYING	A	-8,733	ADMINISTRATION & GENERAL	5.01	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	ADVERTISING - LAHARPE	A	0	RURAL HEALTH CLINIC	88.00	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-79,144	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTISING- RHC	A	-23,865	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	ADVERTISING - WOMENS & FAMILY RHC	A	0	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-45,524	ADMINISTRATION & GENERAL	5.01	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-10,340	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-6,688	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	AMORT OF BOND COSTS	A	0	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.01
45.02	RENTAL INCOME - MIDWEST	B	0	CLINIC	90.00	0	45.02
45.03	PROVIDER TAX	A	-587,760	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-7,569	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-36,438	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06	PHYSICIAN RECRUITMENT	A	-165	ADMINISTRATION & GENERAL	5.01	0	45.06
45.07	ADVERTISING - NAUVOO	A	0	RURAL HEALTH CLINIC	88.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-11,812	ADMINISTRATION & GENERAL	5.01	0	45.08
45.09	RADIOLOGY	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	MARKETING SALARIES	A	-73,090	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-16,608	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTHAGE INTEREST	A	0	ADMINISTRATION & GENERAL	5.01	0	45.12
45.13	ADVERTISING - COLCHSTR	A	0	RURAL HEALTH CLINIC	88.00	0	45.13
45.14	340B PHARMACY	A	-432,992	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
45.15	GEROPSYCH	B	0	DIETARY	10.00	0	45.15
45.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,580,802				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
6/12/2020 2:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.01	ADMINISTRATION & GENERAL	CORP ADMIN ASSESSMENT	0	154,012	1.00
2.00	5.01	ADMINISTRATION & GENERAL	REVENUE CYCLE ASSESSMENT	0	34,744	2.00
3.00	5.01	ADMINISTRATION & GENERAL	IT ASSESSMENT	0	22,375	3.00
4.00	5.01	ADMINISTRATION & GENERAL	CON SVC OPERATIONS ASSESSMEN	0	2,622	4.00
4.01	5.01	ADMINISTRATION & GENERAL	SOFTWARE MAINTENANCE	0	268,212	4.01
4.02	5.01	ADMINISTRATION & GENERAL	HOME OFFICE ALLOCATION	1,240,376	0	4.02
5.00	TOTALS (sum of lines 1-4).			1,240,376	481,965	5.00
	Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	UNITYPOINT HEAL	100.00	UNITYPOINT HEAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
6/12/2020 2:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-154,012	0		1.00
2.00	-34,744	0		2.00
3.00	-22,375	0		3.00
4.00	-2,622	0		4.00
4.01	-268,212	0		4.01
4.02	1,240,376	0		4.02
5.00	758,411			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	
Type of Business	
6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
6/12/2020 2:36 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	60.00	LABORATORY	50,000	0	50,000	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	60,285	60,285	0	0	0	2.00
3.00	60.02	GEO PSYCH	42,657	42,657	0	0	0	3.00
4.00	50.00	OPERATING ROOM	311,414	311,414	0	0	0	4.00
5.00	90.00	CLINIC	129,122	129,122	0	0	0	5.00
6.00	91.00	EMERGENCY	1,856,930	370,272	1,486,658	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	15,479	15,479	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,465,887	929,229	1,536,658		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	60,285		2.00
3.00	60.02	GEO PSYCH	0	0	0	42,657		3.00
4.00	50.00	OPERATING ROOM	0	0	0	311,414		4.00
5.00	90.00	CLINIC	0	0	0	129,122		5.00
6.00	91.00	EMERGENCY	0	0	0	370,272		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	15,479		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	929,229		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2020 2:36 pm		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.80	7.00
8.00	Optional travel expense rate per mile						0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	378.38	434.25	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	84.49	63.37	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)	42.25	42.25	31.69			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)						31,969	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						27,518	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						59,487	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)						59,487	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						59,487	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
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
6/12/2020 2:36 pm

		Physical Therapy				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.49	63.37	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					59,487	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)					59,487	63.00
64.00	Total cost of outside supplier services (from your records)					64,545	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					5,058	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2020 2:36 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	212.25	370.10	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.08	60.06	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)	40.04	40.04	30.03			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)					16,997	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					22,228	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					39,225	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)					39,225	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)					67.36	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,541	22.00
23.00	Total salary equivalency (see instructions)					52,541	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: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2020 2:36 pm		
				Occupational Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.08	60.06	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						52,541	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)						52,541	63.00
64.00	Total cost of outside supplier services (from your records)						54,852	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						2,311	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2020 2:36 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.80	7.00
8.00	Optional travel expense rate per mile						0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	61.42	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	76.95	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)	38.48	38.48	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	1,890	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)						4,726	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)						4,726	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)						4,726	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)						76.95	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						60,021	22.00
23.00	Total salary equivalency (see instructions)						60,021	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)						1,096	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
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
6/12/2020 2:36 pm

		Speech Pathology				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.95	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					60,021	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)					60,021	63.00
64.00	Total cost of outside supplier services (from your records)					5,835	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: 14-1305

Period:
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Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB		NEW MVBLE EQUIP
			0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	15,314	15,314				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,622,454	0	1,622,454			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	374,775	0	0	374,775		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	786,452				786,452	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	82,991				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,112,100	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	4,657,990	5,390	445,214	149,236	225,432	5.01
7.00	00700	OPERATION OF PLANT	749,407	670	76,790	0	36,777	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,660	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	76,558	0	6,649	0	2,714	8.00
9.00	00900	HOUSEKEEPING	199,939	0	16,659	3,013	6,801	9.00
10.00	01000	DIETARY	200,150	0	31,490	0	12,855	10.00
11.00	01100	CAFETERIA	106,393	0	17,937	0	7,323	11.00
13.00	01300	NURSING ADMINISTRATION	161,623	0	9,681	0	3,952	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,455	1,651	28,751	0	25,114	16.00
17.00	01700	SOCIAL SERVICE	81,017	0	6,393	0	2,610	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	508,587	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,534,447	0	357,355	0	145,885	30.00
43.00	04300	NURSERY	297,180	0	8,220	0	3,356	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	592,572	0	146,383	0	59,759	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,950	0	32,367	0	13,213	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,044,649	0	161,800	0	66,052	54.00
56.00	05600	RADIOISOTOPE	103,788	0	11,325	0	4,623	56.00
60.00	06000	LABORATORY	1,564,595	0	61,666	0	25,174	60.00
60.02	06002	GEO PSYCH	167,369	0	0	14,571	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	34,166	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	221,571	0	25,244	0	10,305	65.00
66.00	06600	PHYSICAL THERAPY	119,348	0	9,462	0	3,863	66.00
69.00	06900	ELECTROCARDIOLOGY	81,910	0	41,098	0	16,778	69.00
69.01	06901	PULMONARY REHAB	51,079	0	0	14,406	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,098	0	11,909	0	4,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,570	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	682,967	0	45,701	0	18,657	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,210,111	7,603	0	99,915	61,623	88.00
90.00	09000	CLINIC	74,560	0	0	15,591	0	90.00
91.00	09100	EMERGENCY	1,959,220	0	67,657	0	27,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	89,756	0	0	9,834	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,887,111	15,314	1,619,751	314,226	785,348	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,703	0	1,104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	609,275	0	0	60,549	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,496,386	15,314	1,622,454	374,775	786,452	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
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Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	4.00	4A	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	82,991					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,112,100				4.00
5.01	00550	ADMINISTRATION & GENERAL	33,048	501,333	6,017,643	6,017,643		5.01
7.00	00700	OPERATION OF PLANT	0	53,539	917,183	256,964	1,174,147	7.00
7.01	00701	OPERATION OF PLANT MOB	1,696	0	9,356	2,621	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	85,921	24,072	7,094	8.00
9.00	00900	HOUSEKEEPING	667	40,043	267,122	74,839	17,774	9.00
10.00	01000	DIETARY	0	25,744	270,239	75,712	33,599	10.00
11.00	01100	CAFETERIA	0	19,392	151,045	42,318	19,138	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,634	201,890	56,563	10,329	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,496	299,467	83,901	30,676	16.00
17.00	01700	SOCIAL SERVICE	0	20,439	110,459	30,947	6,821	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	120,843	629,430	176,346	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	321,058	2,358,745	660,843	381,289	30.00
43.00	04300	NURSEY	0	41,730	350,486	98,195	8,770	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	98,881	897,595	251,476	156,187	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,807	133,337	37,357	34,535	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	143,801	1,416,302	396,801	172,635	54.00
56.00	05600	RADIOISOTOPE	0	0	119,736	33,546	12,083	56.00
60.00	06000	LABORATORY	0	184,690	1,836,125	514,422	65,796	60.00
60.02	06002	GEO PSYCH	3,227	37,198	222,365	62,299	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	34,166	9,572	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	43,868	300,988	84,327	26,934	65.00
66.00	06600	PHYSICAL THERAPY	0	0	132,673	37,171	10,095	66.00
69.00	06900	ELECTROCARDIOLOGY	0	16,217	156,003	43,707	43,851	69.00
69.01	06901	PULMONARY REHAB	3,190	12,353	81,028	22,701	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,026	35,895	10,057	12,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	32,570	9,125	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,118	795,443	222,857	48,762	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	22,125	1,030,306	6,431,683	1,801,951	0	88.00
90.00	09000	CLINIC	3,452	20,844	114,447	32,064	0	90.00
91.00	09100	EMERGENCY	0	104,046	2,158,543	604,753	72,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,178	21,883	123,651	34,643	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,583	2,994,289	26,691,536	5,792,150	1,171,263	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,807	1,067	2,884	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,408	117,811	801,043	224,426	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	82,991	3,112,100	27,496,386	6,017,643	1,174,147	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	11,977					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,087				8.00
9.00	00900	HOUSEKEEPING	166	0	359,901			9.00
10.00	01000	DIETARY	0	0	6,351	385,901		10.00
11.00	01100	CAFETERIA	0	0	3,618	0	216,119	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,952	0	4,999	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,408	0	10,559	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,289	0	4,232	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,093	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	45,508	72,073	385,901	40,568	30.00
43.00	04300	NURSERY	0	0	1,658	0	5,820	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	35,061	29,523	0	11,494	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,528	0	1,227	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,061	32,633	0	20,276	54.00
56.00	05600	RADIOISOTOPE	0	0	2,284	0	0	56.00
60.00	06000	LABORATORY	0	0	12,437	0	29,515	60.00
60.02	06002	GEO PSYCH	801	0	7,162	0	6,421	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,091	0	6,677	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,908	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,289	0	2,468	69.00
69.01	06901	PULMONARY REHAB	792	0	7,081	0	2,264	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,402	0	1,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,217	0	4,935	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,492	5,905	79,552	0	44,273	88.00
90.00	09000	CLINIC	857	599	7,663	0	0	90.00
91.00	09100	EMERGENCY	0	15,953	13,645	0	13,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	541	0	4,833	0	3,430	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,649	117,087	329,597	385,901	216,119	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	545	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,328	0	29,759	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,977	117,087	359,901	385,901	216,119	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	275,733					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	437,011				16.00
17.00	01700	SOCIAL SERVICE	0	0	153,748			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,239	0	0	814,108		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	120,946	30,354	150,673	0	4,246,900	30.00
43.00	04300	NURSERY	17,351	1,606	0	0	483,886	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,268	21,701	0	0	1,437,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,658	3,160	0	0	219,802	52.00
53.00	05300	ANESTHESIOLOGY	0	11,817	0	814,108	825,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,576	0	0	2,151,284	54.00
56.00	05600	RADIOISOTOPE	0	1,977	0	0	169,626	56.00
60.00	06000	LABORATORY	0	111,423	0	0	2,569,718	60.00
60.02	06002	GEO PSYCH	0	4,147	0	0	303,195	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	495	0	0	44,233	62.00
65.00	06500	RESPIRATORY THERAPY	19,905	8,393	0	0	452,315	65.00
66.00	06600	PHYSICAL THERAPY	0	2,692	0	0	184,539	66.00
69.00	06900	ELECTROCARDIOLOGY	7,358	5,864	0	0	267,540	69.00
69.01	06901	PULMONARY REHAB	0	4,241	0	0	118,107	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,398	0	0	66,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	564	0	0	42,259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,713	22,899	0	0	1,118,826	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	73,965	0	0	8,442,821	88.00
90.00	09000	CLINIC	0	634	0	0	156,264	90.00
91.00	09100	EMERGENCY	41,069	27,776	3,075	0	2,950,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	10,226	329	0	0	177,653	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	275,733	437,011	153,748	814,108	26,429,527	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,303	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,058,556	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	275,733	437,011	153,748	814,108	27,496,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
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To 12/31/2019Worksheet B
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
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	0	4,246,900	30.00
43.00	04300	NURSERY	0	483,886	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,437,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,802	52.00
53.00	05300	ANESTHESIOLOGY	0	825,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,151,284	54.00
56.00	05600	RADIOISOTOPE	0	169,626	56.00
60.00	06000	LABORATORY	0	2,569,718	60.00
60.02	06002	GEO PSYCH	0	303,195	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	44,233	62.00
65.00	06500	RESPIRATORY THERAPY	0	452,315	65.00
66.00	06600	PHYSICAL THERAPY	0	184,539	66.00
69.00	06900	ELECTROCARDIOLOGY	0	267,540	69.00
69.01	06901	PULMONARY REHAB	0	118,107	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,118,826	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	8,442,821	88.00
90.00	09000	CLINIC	0	156,264	90.00
91.00	09100	EMERGENCY	0	2,950,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	177,653	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,429,527	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,303	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,058,556	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	27,496,386	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
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To 12/31/2019Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
		0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	5,390	445,214	149,236	225,432
7.00	00700	OPERATION OF PLANT	0	670	76,790	0	36,777
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,660	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,649	0	2,714
9.00	00900	HOUSEKEEPING	0	0	16,659	3,013	6,801
10.00	01000	DIETARY	0	0	31,490	0	12,855
11.00	01100	CAFETERIA	0	0	17,937	0	7,323
13.00	01300	NURSING ADMINISTRATION	0	0	9,681	0	3,952
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,651	28,751	0	25,114
17.00	01700	SOCIAL SERVICE	0	0	6,393	0	2,610
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	357,355	0	145,885
43.00	04300	NURSERY	0	0	8,220	0	3,356
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	146,383	0	59,759
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	32,367	0	13,213
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	161,800	0	66,052
56.00	05600	RADIOISOTOPE	0	0	11,325	0	4,623
60.00	06000	LABORATORY	0	0	61,666	0	25,174
60.02	06002	GEO PSYCH	0	0	0	14,571	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	25,244	0	10,305
66.00	06600	PHYSICAL THERAPY	0	0	9,462	0	3,863
69.00	06900	ELECTROCARDIOLOGY	0	0	41,098	0	16,778
69.01	06901	PULMONARY REHAB	0	0	0	14,406	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11,909	0	4,862
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	45,701	0	18,657
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	7,603	0	99,915	61,623
90.00	09000	CLINIC	0	0	0	15,591	0
91.00	09100	EMERGENCY	0	0	67,657	0	27,620
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04950	DIABETIC EDUCATION	0	0	0	9,834	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,314	1,619,751	314,226	785,348
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,703	0	1,104
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	60,549	0
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0
194.02	07951	BEAUTY SHOP	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	15,314	1,622,454	374,775	786,452

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
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Cost Center Description			CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	2A	4.00	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	33,048	858,320	0	858,320		5.01
7.00	00700	OPERATION OF PLANT	0	114,237	0	36,652	150,889	7.00
7.01	00701	OPERATION OF PLANT MOB	1,696	9,356	0	374	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,363	0	3,433	912	8.00
9.00	00900	HOUSEKEEPING	667	27,140	0	10,674	2,284	9.00
10.00	01000	DIETARY	0	44,345	0	10,799	4,318	10.00
11.00	01100	CAFETERIA	0	25,260	0	6,036	2,459	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,633	0	8,068	1,327	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,516	0	11,967	3,942	16.00
17.00	01700	SOCIAL SERVICE	0	9,003	0	4,414	877	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	25,153	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	503,240	0	94,258	49,001	30.00
43.00	04300	NURSERY	0	11,576	0	14,006	1,127	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	206,142	0	35,869	20,071	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,580	0	5,328	4,438	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	227,852	0	56,597	22,185	54.00
56.00	05600	RADIOISOTOPE	0	15,948	0	4,785	1,553	56.00
60.00	06000	LABORATORY	0	86,840	0	73,373	8,455	60.00
60.02	06002	GEO PSYCH	3,227	17,798	0	8,886	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,365	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	35,549	0	12,028	3,461	65.00
66.00	06600	PHYSICAL THERAPY	0	13,325	0	5,302	1,297	66.00
69.00	06900	ELECTROCARDIOLOGY	0	57,876	0	6,234	5,635	69.00
69.01	06901	PULMONARY REHAB	3,190	17,596	0	3,238	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,771	0	1,434	1,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,302	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,358	0	31,787	6,266	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	22,125	191,266	0	257,024	0	88.00
90.00	09000	CLINIC	3,452	19,043	0	4,573	0	90.00
91.00	09100	EMERGENCY	0	95,277	0	86,258	9,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,178	12,012	0	4,941	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,583	2,804,222	0	826,158	150,518	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,807	0	152	371	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,408	73,957	0	32,010	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	82,991	2,881,986	0	858,320	150,889	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	9,730					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,708				8.00
9.00	00900	HOUSEKEEPING	135	0	40,233			9.00
10.00	01000	DIETARY	0	0	710	60,172		10.00
11.00	01100	CAFETERIA	0	0	404	0	34,159	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	218	0	790	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,387	0	1,669	16.00
17.00	01700	SOCIAL SERVICE	0	0	144	0	669	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	331	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,328	8,057	60,172	6,412	30.00
43.00	04300	NURSERY	0	0	185	0	920	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,105	3,300	0	1,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	730	0	194	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,646	3,648	0	3,205	54.00
56.00	05600	RADIOISOTOPE	0	0	255	0	0	56.00
60.00	06000	LABORATORY	0	0	1,390	0	4,665	60.00
60.02	06002	GEO PSYCH	651	0	801	0	1,015	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	569	0	1,055	65.00
66.00	06600	PHYSICAL THERAPY	0	0	213	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	927	0	390	69.00
69.01	06901	PULMONARY REHAB	643	0	792	0	358	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	269	0	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,030	0	780	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,462	691	8,894	0	6,997	88.00
90.00	09000	CLINIC	696	70	857	0	0	90.00
91.00	09100	EMERGENCY	0	1,868	1,525	0	2,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	439	0	540	0	542	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,026	13,708	36,845	60,172	34,159	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	61	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,704	0	3,327	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,730	13,708	40,233	60,172	34,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
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To 12/31/2019Worksheet B
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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	24,036					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,481				16.00
17.00	01700	SOCIAL SERVICE	0	0	15,107			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	544	0	0	26,028		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,544	5,172	14,805		756,989	30.00
43.00	04300	NURSERY	1,512	274	0		29,600	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,987	3,698	0		277,989	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	319	538	0		57,127	52.00
53.00	05300	ANESTHESIOLOGY	0	2,014	0		2,014	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,796	0		331,929	54.00
56.00	05600	RADIOISOTOPE	0	337	0		22,878	56.00
60.00	06000	LABORATORY	0	19,003	0		193,726	60.00
60.02	06002	GEO PSYCH	0	707	0		29,858	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	84	0		1,449	62.00
65.00	06500	RESPIRATORY THERAPY	1,735	1,430	0		55,827	65.00
66.00	06600	PHYSICAL THERAPY	0	459	0		20,596	66.00
69.00	06900	ELECTROCARDIOLOGY	641	999	0		72,702	69.00
69.01	06901	PULMONARY REHAB	0	723	0		23,350	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749	0		21,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	96	0		1,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,283	3,902	0		109,406	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	12,603	0		481,937	88.00
90.00	09000	CLINIC	0	108	0		25,347	90.00
91.00	09100	EMERGENCY	3,580	4,733	302		204,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	891	56	0		19,421	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,036	74,481	15,107	0	2,739,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		4,391	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		111,998	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0		0	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				26,028	26,028	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,036	74,481	15,107	26,028	2,881,986	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
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
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	0	756,989		30.00
43.00	04300	NURSERY	0	29,600		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	277,989		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,127		52.00
53.00	05300	ANESTHESIOLOGY	0	2,014		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	331,929		54.00
56.00	05600	RADIOISOTOPE	0	22,878		56.00
60.00	06000	LABORATORY	0	193,726		60.00
60.02	06002	GEO PSYCH	0	29,858		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,449		62.00
65.00	06500	RESPIRATORY THERAPY	0	55,827		65.00
66.00	06600	PHYSICAL THERAPY	0	20,596		66.00
69.00	06900	ELECTROCARDIOLOGY	0	72,702		69.00
69.01	06901	PULMONARY REHAB	0	23,350		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,029		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,398		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	109,406		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	481,937		88.00
90.00	09000	CLINIC	0	25,347		90.00
91.00	09100	EMERGENCY	0	204,997		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	19,421		93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,739,569		118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,391		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,998		192.00
194.00	07950	NAUV00 APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	26,028		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,881,986		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADM IN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322				1.00	
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	44,412			1.02	
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000		1.03	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				52,734	2.00	
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5.01	00550	ADMINISTRATION & GENERAL	2,929	12,187	9,955	15,116	9,955	
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	
9.00	00900	HOUSEKEEPING	0	456	201	456	201	
10.00	01000	DIETARY	0	862	0	862	0	
11.00	01100	CAFETERIA	0	491	0	491	0	
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	
43.00	04300	NURSERY	0	225	0	225	0	
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	
56.00	05600	RADIOISOTOPE	0	310	0	310	0	
60.00	06000	LABORATORY	0	1,688	0	1,688	0	
60.02	06002	GEO PSYCH	0	0	972	0	972	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	
69.01	06901	PULMONARY REHAB	0	0	961	0	961	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	1,251	0	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,132	0	6,665	4,132	6,665	
90.00	09000	CLINIC	0	0	1,040	0	1,040	
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,322	44,338	20,961	52,660	20,961	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	
194.02	07951	BEAUTY SHOP	0	0	0	0	0	
200.00		Cross Foot Adjustments						
201.00		Negative Cost Centers						
202.00		Cost to be allocated (per Wkst. B, Part I)	15,314	1,622,454	374,775	786,452	82,991	
203.00		Unit cost multiplier (Wkst. B, Part I)	1.840183	36.531883	14.991000	14.913566	3.319640	
204.00		Cost to be allocated (per Wkst. B, Part II)						
205.00		Unit cost multiplier (Wkst. B, Part II)						
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,336,088					4.00
5.01	00550	ADMINISTRATION & GENERAL	1,987,239	-6,017,643	21,478,743			5.01
7.00	00700	OPERATION OF PLANT	212,224	0	917,183	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	9,356	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	85,921	182	0	8.00
9.00	00900	HOUSEKEEPING	158,727	0	267,122	456	201	9.00
10.00	01000	DIETARY	102,047	0	270,239	862	0	10.00
11.00	01100	CAFETERIA	76,868	0	151,045	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	105,576	0	201,890	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,308	0	299,467	787	0	16.00
17.00	01700	SOCIAL SERVICE	81,017	0	110,459	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	479,010	0	629,430	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,272,644	0	2,358,745	9,782	0	30.00
43.00	04300	NURSERY	165,413	0	350,486	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	391,956	0	897,595	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,909	0	133,337	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,013	0	1,416,302	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	119,736	310	0	56.00
60.00	06000	LABORATORY	732,094	0	1,836,125	1,688	0	60.00
60.02	06002	GEO PSYCH	147,448	0	222,365	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	34,166	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	173,889	0	300,988	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	132,673	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	64,283	0	156,003	1,125	0	69.00
69.01	06901	PULMONARY REHAB	48,966	0	81,028	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,886	0	35,895	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	32,570	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,737	0	795,443	1,251	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,084,047	0	6,431,683	0	6,665	88.00
90.00	09000	CLINIC	82,623	0	114,447	0	1,040	90.00
91.00	09100	EMERGENCY	412,428	0	2,158,543	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	86,744	0	123,651	0	656	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,869,096	-6,017,643	20,673,893	30,049	10,495	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,807	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	466,992	0	801,043	0	4,039	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,112,100		6,017,643	1,174,147	11,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.252276		0.280167	38.978422	0.824068	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		858,320	150,889	9,730	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.039961	5.009096	0.669465	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102 NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103 CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550 ADMINISTRATION & GENERAL						5.01
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT MOB						7.01
8.00	00800 LAUNDRY & LINEN SERVICE	41,660					8.00
9.00	00900 HOUSEKEEPING	0	48,847				9.00
10.00	01000 DIETARY	0	862	1,907			10.00
11.00	01100 CAFETERIA	0	491	0	215,419		11.00
13.00	01300 NURSING ADMINISTRATION	0	265	0	4,983	92,188	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1,684	0	10,525	0	16.00
17.00	01700 SOCIAL SERVICE	0	175	0	4,218	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	2,086	2,086	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,192	9,782	1,907	40,437	40,437	30.00
43.00	04300 NURSERY	0	225	0	5,801	5,801	43.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,475	4,007	0	11,457	11,457	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	886	0	1,223	1,223	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,003	4,429	0	20,210	0	54.00
56.00	05600 RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000 LABORATORY	0	1,688	0	29,419	0	60.00
60.02	06002 GEO PSYCH	0	972	0	6,400	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	691	0	6,655	6,655	65.00
66.00	06600 PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,125	0	2,460	2,460	69.00
69.01	06901 PULMONARY REHAB	0	961	0	2,257	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	1,088	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,251	0	4,919	4,919	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	2,101	10,797	0	44,131	0	88.00
90.00	09000 CLINIC	213	1,040	0	0	0	90.00
91.00	09100 EMERGENCY	5,676	1,852	0	13,731	13,731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	0	656	0	3,419	3,419	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41,660	44,734	1,907	215,419	92,188	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	4,039	0	0	0	192.00
194.00	07950 NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951 BEAUTY SHOP	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	117,087	359,901	385,901	216,119	275,733	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.810538	7.367924	202.360252	1.003249	2.990986	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,708	40,233	60,172	34,159	24,036	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.329045	0.823653	31.553225	0.158570	0.260728	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet B-1
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY	48,541,058			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,371,591	98	0	30.00
43.00	04300	NURSERY	178,347	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,410,379	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	350,985	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,312,595	0	2,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,949,246	0	0	54.00
56.00	05600	RADIOISOTOPE	219,640	0	0	56.00
60.00	06000	LABORATORY	12,376,709	0	0	60.00
60.02	06002	GEO PSYCH	460,635	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	54,998	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	932,240	0	0	65.00
66.00	06600	PHYSICAL THERAPY	299,008	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	651,313	0	0	69.00
69.01	06901	PULMONARY REHAB	471,038	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	488,464	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,620	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,543,488	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,215,633	0	0	88.00
90.00	09000	CLINIC	70,392	0	0	90.00
91.00	09100	EMERGENCY	3,085,230	2	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	36,507	0	0	93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,541,058	100	2,080	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	437,011	153,748	814,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009003	1,537.480000	391.398077	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,481	15,107	26,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001534	151.070000	12.513462	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/12/2020 2:36 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,246,900		4,246,900	0
43.00	04300	NURSERY	483,886		483,886	0
46.00	04600	OTHER LONG TERM CARE	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,437,305		1,437,305	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,802		219,802	0
53.00	05300	ANESTHESIOLOGY	825,925		825,925	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,151,284		2,151,284	0
56.00	05600	RADIOISOTOPE	169,626		169,626	0
60.00	06000	LABORATORY	2,569,718		2,569,718	0
60.02	06002	GEO PSYCH	303,195		303,195	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,233		44,233	0
65.00	06500	RESPIRATORY THERAPY	452,315	0	452,315	0
66.00	06600	PHYSICAL THERAPY	184,539	0	184,539	0
69.00	06900	ELECTROCARDIOLOGY	267,540		267,540	0
69.01	06901	PULMONARY REHAB	118,107		118,107	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,551		66,551	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,259		42,259	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,118,826		1,118,826	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,442,821		8,442,821	0
90.00	09000	CLINIC	156,264		156,264	0
91.00	09100	EMERGENCY	2,950,778		2,950,778	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	504,146		504,146	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0
93.01	04950	DIABETIC EDUCATION	177,653		177,653	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	26,933,673	0	26,933,673	0
201.00		Less Observation Beds	504,146		504,146	0
202.00		Total (see instructions)	26,429,527	0	26,429,527	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/12/2020 2:36 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	2,391,436		2,391,436			30.00
43.00	04300	NURSERY	178,347		178,347			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	593,564	1,816,815	2,410,379	0.596298	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,662	141,323	350,985	0.626243	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	25,148	1,287,447	1,312,595	0.629231	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	557,428	10,391,818	10,949,246	0.196478	0.000000	54.00
56.00	05600	RADIOISOTOPE	8,600	211,040	219,640	0.772291	0.000000	56.00
60.00	06000	LABORATORY	1,055,381	11,321,328	12,376,709	0.207625	0.000000	60.00
60.02	06002	GEO PSYCH	0	460,635	460,635	0.658211	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,922	32,076	54,998	0.804266	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	250,504	681,736	932,240	0.485192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	297,310	1,698	299,008	0.617171	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	21,793	629,520	651,313	0.410770	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	471,038	471,038	0.250738	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	293,820	194,644	488,464	0.136245	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,000	57,620	62,620	0.674848	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,010,865	1,532,623	2,543,488	0.439879	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	8,215,633	8,215,633			88.00
90.00	09000	CLINIC	0	70,392	70,392	2.219911	0.000000	90.00
91.00	09100	EMERGENCY	45,063	3,040,167	3,085,230	0.956421	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,820	923,335	980,155	0.514353	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	36,507	36,507	4.866272	0.000000	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,023,663	41,517,395	48,541,058			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,023,663	41,517,395	48,541,058			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/12/2020 2:36 pm
				Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.000000			60.00
60.02	06002	GEO PSYCH	0.000000			60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	PULMONARY REHAB	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.01	04950	DIABETIC EDUCATION	0.000000			93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,246,900		4,246,900	0	4,246,900	30.00
43.00	04300	NURSERY	483,886		483,886	0	483,886	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,437,305		1,437,305	0	1,437,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,802		219,802	0	219,802	52.00
53.00	05300	ANESTHESIOLOGY	825,925		825,925	0	825,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,151,284		2,151,284	0	2,151,284	54.00
56.00	05600	RADIOISOTOPE	169,626		169,626	0	169,626	56.00
60.00	06000	LABORATORY	2,569,718		2,569,718	0	2,569,718	60.00
60.02	06002	GEO PSYCH	303,195		303,195	0	303,195	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,233		44,233	0	44,233	62.00
65.00	06500	RESPIRATORY THERAPY	452,315	0	452,315	0	452,315	65.00
66.00	06600	PHYSICAL THERAPY	184,539	5,058	189,597	0	189,597	66.00
69.00	06900	ELECTROCARDIOLOGY	267,540		267,540	0	267,540	69.00
69.01	06901	PULMONARY REHAB	118,107		118,107	0	118,107	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,551		66,551	0	66,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,259		42,259	0	42,259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,118,826		1,118,826	0	1,118,826	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,442,821		8,442,821	0	8,442,821	88.00
90.00	09000	CLINIC	156,264		156,264	0	156,264	90.00
91.00	09100	EMERGENCY	2,950,778		2,950,778	0	2,950,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	504,146		504,146		504,146	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	177,653		177,653	0	177,653	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,933,673	0	26,938,731	0	26,938,731	200.00
201.00		Less Observation Beds	504,146		504,146		504,146	201.00
202.00		Total (see instructions)	26,429,527	0	26,434,585	0	26,434,585	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/12/2020 2:36 pm

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,391,436		2,391,436			30.00
43.00	04300	NURSERY	178,347		178,347			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	593,564	1,816,815	2,410,379	0.596298	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,662	141,323	350,985	0.626243	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	25,148	1,287,447	1,312,595	0.629231	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	557,428	10,391,818	10,949,246	0.196478	0.000000	54.00
56.00	05600	RADIOISOTOPE	8,600	211,040	219,640	0.772291	0.000000	56.00
60.00	06000	LABORATORY	1,055,381	11,321,328	12,376,709	0.207625	0.000000	60.00
60.02	06002	GEO PSYCH	0	460,635	460,635	0.658211	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,922	32,076	54,998	0.804266	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	250,504	681,736	932,240	0.485192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	297,310	1,698	299,008	0.617171	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	21,793	629,520	651,313	0.410770	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	471,038	471,038	0.250738	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	293,820	194,644	488,464	0.136245	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,000	57,620	62,620	0.674848	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,010,865	1,532,623	2,543,488	0.439879	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	8,215,633	8,215,633	1.027653	0.000000	88.00
90.00	09000	CLINIC	0	70,392	70,392	2.219911	0.000000	90.00
91.00	09100	EMERGENCY	45,063	3,040,167	3,085,230	0.956421	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,820	923,335	980,155	0.514353	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	36,507	36,507	4.866272	0.000000	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,023,663	41,517,395	48,541,058			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,023,663	41,517,395	48,541,058			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/12/2020 2:36 pm
				Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.596298			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.626243			52.00
53.00	05300	ANESTHESIOLOGY	0.629231			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196478			54.00
56.00	05600	RADIOISOTOPE	0.772291			56.00
60.00	06000	LABORATORY	0.207625			60.00
60.02	06002	GEO PSYCH	0.658211			60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.804266			62.00
65.00	06500	RESPIRATORY THERAPY	0.485192			65.00
66.00	06600	PHYSICAL THERAPY	0.634087			66.00
69.00	06900	ELECTROCARDIOLOGY	0.410770			69.00
69.01	06901	PULMONARY REHAB	0.250738			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136245			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.674848			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439879			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.027653			88.00
90.00	09000	CLINIC	2.219911			90.00
91.00	09100	EMERGENCY	0.956421			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514353			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.01	04950	DIABETIC EDUCATION	4.866272			93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,437,305	277,989	1,159,316	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,802	57,127	162,675	0	0	52.00
53.00	05300	ANESTHESIOLOGY	825,925	2,014	823,911	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,151,284	331,929	1,819,355	0	0	54.00
56.00	05600	RADIOISOTOPE	169,626	22,878	146,748	0	0	56.00
60.00	06000	LABORATORY	2,569,718	193,726	2,375,992	0	0	60.00
60.02	06002	GEO PSYCH	303,195	29,858	273,337	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,233	1,449	42,784	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	452,315	55,827	396,488	0	0	65.00
66.00	06600	PHYSICAL THERAPY	184,539	20,596	163,943	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	267,540	72,702	194,838	0	0	69.00
69.01	06901	PULMONARY REHAB	118,107	23,350	94,757	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,551	21,029	45,522	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,259	1,398	40,861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,118,826	109,406	1,009,420	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,442,821	481,937	7,960,884	0	0	88.00
90.00	09000	CLINIC	156,264	25,347	130,917	0	0	90.00
91.00	09100	EMERGENCY	2,950,778	204,997	2,745,781	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	504,146	89,862	414,284	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	177,653	19,421	158,232	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	22,202,887	2,042,842	20,160,045	0	0	200.00
201.00		Less Observation Beds	504,146	89,862	414,284	0	0	201.00
202.00		Total (line 200 minus line 201)	21,698,741	1,952,980	19,745,761	0	0	202.00

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

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,437,305	2,410,379	0.596298		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	219,802	350,985	0.626243		52.00
53.00	05300 ANESTHESIOLOGY	825,925	1,312,595	0.629231		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,151,284	10,949,246	0.196478		54.00
56.00	05600 RADIOISOTOPE	169,626	219,640	0.772291		56.00
60.00	06000 LABORATORY	2,569,718	12,376,709	0.207625		60.00
60.02	06002 GEO PSYCH	303,195	460,635	0.658211		60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	44,233	54,998	0.804266		62.00
65.00	06500 RESPIRATORY THERAPY	452,315	932,240	0.485192		65.00
66.00	06600 PHYSICAL THERAPY	184,539	299,008	0.617171		66.00
69.00	06900 ELECTROCARDIOLOGY	267,540	651,313	0.410770		69.00
69.01	06901 PULMONARY REHAB	118,107	471,038	0.250738		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	66,551	488,464	0.136245		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42,259	62,620	0.674848		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,118,826	2,543,488	0.439879		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	8,442,821	8,215,633	1.027653		88.00
90.00	09000 CLINIC	156,264	70,392	2.219911		90.00
91.00	09100 EMERGENCY	2,950,778	3,085,230	0.956421		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	504,146	980,155	0.514353		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04950 DIABETIC EDUCATION	177,653	36,507	4.866272		93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0.000000		95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	22,202,887	45,971,275			200.00
201.00	Less Observation Beds	504,146	0			201.00
202.00	Total (line 200 minus line 201)	21,698,741	45,971,275			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	277,989	2,410,379	0.115330	47,428	5,470
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,127	350,985	0.162762	0	0
53.00	05300	ANESTHESIOLOGY	2,014	1,312,595	0.001534	19,441	30
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,929	10,949,246	0.030315	283,997	8,609
56.00	05600	RADIOISOTOPE	22,878	219,640	0.104161	5,295	552
60.00	06000	LABORATORY	193,726	12,376,709	0.015652	306,535	4,798
60.02	06002	GEO PSYCH	29,858	460,635	0.064819	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,449	54,998	0.026346	12,805	337
65.00	06500	RESPIRATORY THERAPY	55,827	932,240	0.059885	126,439	7,572
66.00	06600	PHYSICAL THERAPY	20,596	299,008	0.068881	2,185	151
69.00	06900	ELECTROCARDIOLOGY	72,702	651,313	0.111624	12,573	1,403
69.01	06901	PULMONARY REHAB	23,350	471,038	0.049571	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,029	488,464	0.043051	124,917	5,378
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,398	62,620	0.022325	4,920	110
73.00	07300	DRUGS CHARGED TO PATIENTS	109,406	2,543,488	0.043014	342,966	14,752
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	481,937	8,215,633	0.058661	0	0
90.00	09000	CLINIC	25,347	70,392	0.360084	0	0
91.00	09100	EMERGENCY	204,997	3,085,230	0.066445	1,534	102
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	89,862	980,155	0.091681	39,297	3,603
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0
93.01	04950	DIABETIC EDUCATION	19,421	36,507	0.531980	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	2,042,842	45,971,275		1,330,332	52,867

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	814,108	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	814,108	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,410,379	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	350,985	0.000000
53.00	05300	ANESTHESIOLOGY	0	814,108	0	1,312,595	0.620228
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,949,246	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	219,640	0.000000
60.00	06000	LABORATORY	0	0	0	12,376,709	0.000000
60.02	06002	GEO PSYCH	0	0	0	460,635	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	54,998	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	932,240	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	299,008	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	651,313	0.000000
69.01	06901	PULMONARY REHAB	0	0	0	471,038	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	488,464	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,620	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,543,488	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,215,633	0.000000
90.00	09000	CLINIC	0	0	0	70,392	0.000000
91.00	09100	EMERGENCY	0	0	0	3,085,230	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	980,155	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000
93.01	04950	DIABETIC EDUCATION	0	0	0	36,507	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	814,108	0	45,971,275	0.000000

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
6/12/2020 2:36 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	47,428	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	19,441	12,058	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	283,997	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	5,295	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	306,535	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	12,805	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	126,439	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,185	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,573	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	124,917	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,920	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	342,966	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,534	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	39,297	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,330,332	12,058	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/12/2020 2:36 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	0.596298	0	524,481	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.626243	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.629231	0	321,742	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196478	0	3,817,890	0	0	54.00
56.00	05600	RADIOISOTOPE	0.772291	0	79,736	0	0	56.00
60.00	06000	LABORATORY	0.207625	0	3,897,236	0	0	60.00
60.02	06002	GEO PSYCH	0.658211	0	387,036	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.804266	0	16,596	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.485192	0	262,465	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.617171	0	732	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.410770	0	192,206	0	0	69.00
69.01	06901	PULMONARY REHAB	0.250738	0	269,576	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136245	0	35,451	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.674848	0	15,455	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439879	0	602,358	288	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.219911	0	21,006	0	0	90.00
91.00	09100	EMERGENCY	0.956421	0	1,203,335	86	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514353	0	139,417	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	4.866272	0	7,592	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	11,794,310	374	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	11,794,310	374	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/12/2020 2:36 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	312,747	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	202,450	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	750,131	0	54.00
56.00	05600	RADIOISOTOPE	61,579	0	56.00
60.00	06000	LABORATORY	809,164	0	60.00
60.02	06002	GEO PSYCH	254,751	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	13,348	0	62.00
65.00	06500	RESPIRATORY THERAPY	127,346	0	65.00
66.00	06600	PHYSICAL THERAPY	452	0	66.00
69.00	06900	ELECTROCARDIOLOGY	78,952	0	69.00
69.01	06901	PULMONARY REHAB	67,593	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,830	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,430	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	264,965	127	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	46,631	0	90.00
91.00	09100	EMERGENCY	1,150,895	82	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	71,710	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	36,945	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,264,919	209	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,264,919	209	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
6/12/2020 2:36 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	0.596298	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.626243	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.629231	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196478	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.772291	0	0	0	0	56.00
60.00	06000	LABORATORY	0.207625	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.658211	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.804266	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.485192	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.617171	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.410770	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.250738	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136245	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.674848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439879	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.219911	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.956421	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514353	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	4.866272	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
6/12/2020 2:36 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
60.00	06000	LABORATORY	0	0					60.00
60.02	06002	GEO PSYCH	0	0					60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	06901	PULMONARY REHAB	0	0					69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0					93.00
93.01	04950	DIABETIC EDUCATION	0	0					93.01
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0					95.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		756,989	282,292	474,697	1,352	351.11	30.00
43.00	NURSERY		29,600		29,600	225	131.56	43.00
200.00	Total (lines 30 through 199)		786,589		504,297	1,577		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		193	67,764				30.00
43.00	NURSERY		107	14,077				43.00
200.00	Total (lines 30 through 199)		300	81,841				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	277,989	2,410,379	0.115330	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,127	350,985	0.162762	0	0 52.00
53.00	05300	ANESTHESIOLOGY	2,014	1,312,595	0.001534	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,929	10,949,246	0.030315	0	0 54.00
56.00	05600	RADIOISOTOPE	22,878	219,640	0.104161	0	0 56.00
60.00	06000	LABORATORY	193,726	12,376,709	0.015652	0	0 60.00
60.02	06002	GEO PSYCH	29,858	460,635	0.064819	0	0 60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,449	54,998	0.026346	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	55,827	932,240	0.059885	0	0 65.00
66.00	06600	PHYSICAL THERAPY	20,596	299,008	0.068881	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	72,702	651,313	0.111624	0	0 69.00
69.01	06901	PULMONARY REHAB	23,350	471,038	0.049571	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,029	488,464	0.043051	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,398	62,620	0.022325	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,406	2,543,488	0.043014	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	481,937	8,215,633	0.058661	0	0 88.00
90.00	09000	CLINIC	25,347	70,392	0.360084	0	0 90.00
91.00	09100	EMERGENCY	204,997	3,085,230	0.066445	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	89,883	980,155	0.091703	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0 93.00
93.01	04950	DIABETIC EDUCATION	19,421	36,507	0.531980	0	0 93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	2,042,863	45,971,275		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 6/12/2020 2:36 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,352	0.00	193	0.00		30.00	
43.00	04300	NURSERY		0	225	0.00	107			43.00	
200.00		Total (lines 30 through 199)		0	1,577		300			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
43.00	04300	NURSERY	0							43.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1305		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/12/2020 2:36 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	814,108	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	814,108	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
6/12/2020 2:36 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,410,379	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	350,985	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	814,108	0	1,312,595	0.620228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,949,246	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	219,640	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	12,376,709	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	460,635	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	54,998	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	932,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	299,008	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	651,313	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	471,038	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	488,464	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,620	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,543,488	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,215,633	0.000000	88.00
90.00	09000	CLINIC	0	0	0	70,392	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,085,230	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	980,155	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	36,507	0.000000	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	814,108	0	45,971,275		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/12/2020 2:36 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,163 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,352 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,096 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			804 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)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			7 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			592 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)			767 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			151.43 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			151.43 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,246,900 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			1,060 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)			0 25.00
26.00	Total swing-bed cost (see instructions)			1,584,385 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,662,515 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,662,515 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)			1,969.31 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,165,832 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,165,832 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/12/2020 2:36 pm

		Title XVIII		Hospital	Cost	
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)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					42.00
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)					435,089
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,600,921
	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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,510,461
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,510,461
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					256
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,969.32
89.00	Observation bed cost (line 87 x line 88) (see instructions)					504,146

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	756,989	4,246,900	0.178245	504,146	89,862	90.00
91.00	Nursing School cost	0	4,246,900	0.000000	504,146	0	91.00
92.00	Allied health cost	0	4,246,900	0.000000	504,146	0	92.00
93.00	All other Medical Education	0	4,246,900	0.000000	504,146	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/12/2020 2:36 pm
Cost Center Description		Title XIX	Hospital	PPS
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,163 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,352 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,096 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			804 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)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			7 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			193 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			225 15.00
16.00	Nursery days (title V or XIX only)			107 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			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,246,900 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)			0 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)			0 25.00
26.00	Total swing-bed cost (see instructions)			1,583,727 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,663,173 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,663,173 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)			1,969.80 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			380,171 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)			380,171 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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)	483,886	225	2,150.60	107	230,114	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					610,285	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)					81,841	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)					81,841	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					528,444	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					256	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,969.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					504,269	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	756,989	4,246,900	0.178245	504,269	89,883
91.00	Nursing School cost	0	4,246,900	0.000000	504,269	0
92.00	Allied health cost	0	4,246,900	0.000000	504,269	0
93.00	All other Medical Education	0	4,246,900	0.000000	504,269	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/12/2020 2:36 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		905,135	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.596298	47,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.626243	0	52.00
53.00	05300	ANESTHESIOLOGY	0.629231	19,441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196478	283,997	54.00
56.00	05600	RADIOISOTOPE	0.772291	5,295	56.00
60.00	06000	LABORATORY	0.207625	306,535	60.00
60.02	06002	GEO PSYCH	0.658211	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.804266	12,805	62.00
65.00	06500	RESPIRATORY THERAPY	0.485192	126,439	65.00
66.00	06600	PHYSICAL THERAPY	0.617171	2,185	66.00
69.00	06900	ELECTROCARDIOLOGY	0.410770	12,573	69.00
69.01	06901	PULMONARY REHAB	0.250738	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136245	124,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.674848	4,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439879	342,966	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	2.219911	0	90.00
91.00	09100	EMERGENCY	0.956421	1,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.514353	39,297	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	4.866272	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,330,332	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,330,332	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305 Component CCN: 14-Z305	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/12/2020 2:36 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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.596298	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.626243	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.629231	1,704	1,072	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196478	34,557	6,790	54.00
56.00	05600 RADIOISOTOPE	0.772291	0	0	56.00
60.00	06000 LABORATORY	0.207625	130,231	27,039	60.00
60.02	06002 GEO PSYCH	0.658211	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.804266	3,312	2,664	62.00
65.00	06500 RESPIRATORY THERAPY	0.485192	63,719	30,916	65.00
66.00	06600 PHYSICAL THERAPY	0.617171	276,938	170,918	66.00
69.00	06900 ELECTROCARDIOLOGY	0.410770	4,479	1,840	69.00
69.01	06901 PULMONARY REHAB	0.250738	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136245	50,992	6,947	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.674848	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.439879	215,760	94,908	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	2.219911	0	0	90.00
91.00	09100 EMERGENCY	0.956421	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.514353	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950 DIABETIC EDUCATION	4.866272	0	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		781,692	343,094	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		781,692		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/12/2020 2:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,265,128	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,265,128	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)		4,307,779	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)		27,581	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,585,339	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,694,859	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,694,859	30.00
31.00	Primary payer payments		337	31.00
32.00	Subtotal (line 30 minus line 31)		2,694,522	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)		304,437	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		197,884	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		301,728	36.00
37.00	Subtotal (see instructions)		2,892,406	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,892,406	40.00
40.01	Sequestration adjustment (see instructions)		57,848	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,448,030	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		386,528	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
6/12/2020 2:36 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,423,382		2,460,592	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	08/07/2019	38,250	08/07/2019	12,562	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)		-38,250		-12,562	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)		1,385,132		2,448,030	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		24,844		386,528	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,409,976		2,834,558	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: 14-1305

Period:

Worksheet E-1

Component CCN: 14-Z305

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
6/12/2020 2:36 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		1,781,500		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	08/07/2019	71,417		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)		71,417		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)		1,852,917		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,286		0	6.02
7.00	Total Medicare program liability (see instructions)		1,827,631		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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
6/12/2020 2:36 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: 14-1305

Period:

Worksheet E-2

Component CCN: 14-Z305

From 01/01/2019
To 12/31/2019Date/Time Prepared:
6/12/2020 2:36 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,525,566	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)		346,525	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		767	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)		1,872,091	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,872,091	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)		1,872,091	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		7,161	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)		1,864,930	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,864,930	0	19.00
19.01	Sequestration adjustment (see instructions)		37,299	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,852,917	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)		-25,286	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: 14-1305	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/12/2020 2:36 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,600,921	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)		1,600,921	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,616,930	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)		1,616,930	19.00
20.00	Deductibles (exclude professional component)		193,616	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,423,314	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,423,314	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,749	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,437	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,749	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,438,751	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)		1,438,751	30.00
30.01	Sequestration adjustment (see instructions)		28,775	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,385,132	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)		24,844	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: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
6/12/2020 2:36 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	5,160,220	0	0	0	1.00
2.00	Temporary investments	51,320	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,872,552	0	0	0	4.00
5.00	Other receivable	627,412	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	340,491	0	0	0	7.00
8.00	Prepaid expenses	188,320	0	0	0	8.00
9.00	Other current assets	15,064	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)	11,255,379	0	0	0	11.00
FIXED ASSETS						
12.00	Land	499,957	0	0	0	12.00
13.00	Land improvements	1,330,154	0	0	0	13.00
14.00	Accumulated depreciation	-518,041	0	0	0	14.00
15.00	Buildings	25,024,053	0	0	0	15.00
16.00	Accumulated depreciation	-13,069,899	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	8,098,388	0	0	0	23.00
24.00	Accumulated depreciation	-5,486,077	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,775,183	0	0	0	28.00
29.00	Minor equipment-nondepreciable	53,815	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,125,936	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,622,389	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	868,182	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,490,571	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,871,886	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,616,870	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,001,845	0	0	0	38.00
39.00	Payroll taxes payable	96,910	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,236,906	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	69,278	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,021,809	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	19,089,600	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	482,930	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,572,530	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,594,339	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,277,547				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)	11,277,547	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,871,886	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
6/12/2020 2:36 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		11,123,766		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		128,744				2.00
3.00	Total (sum of line 1 and line 2)		11,252,510		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	25,037		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)		25,037		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,277,547		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)		11,277,547		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	RESTRICTED CONTRIBUTIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			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: 14-1305

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/12/2020 2:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,936,833		2,936,833	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,936,833		2,936,833	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)	2,936,833		2,936,833	17.00
18.00	Ancillary services	4,351,997	29,188,132	33,540,129	18.00
19.00	Outpatient services	101,883	7,224,231	7,326,114	19.00
20.00	RURAL HEALTH CLINIC	0	8,215,633	8,215,633	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	879,200	879,200	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,390,713	45,507,196	52,897,909	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,074,877		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)		29,074,877		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
6/12/2020 2:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,897,909	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,631,938	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,265,971	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,074,877	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,808,906	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	426,794	6.00
7.00	Income from investments	737,059	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	11,812	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	45,980	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	331	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	56,720	22.00
23.00	Governmental appropriations	64,862	23.00
24.00	HOSPITAL OTHER INCOME	7,569	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	RELEASED FROM RESTRICTION	0	24.03
24.04	340B PHARMACY REVENUE	1,574,471	24.04
24.05	SALARY REIMBURSEMENTS	37,321	24.05
24.06	EHR INCENTIVE	15,547	24.06
24.07	OTHER (SPECIFY)	0	24.07
25.00	Total other income (sum of lines 6-24)	2,978,466	25.00
26.00	Total (line 5 plus line 25)	169,560	26.00
27.00	LOSS ON DISPOSAL	6,737	27.00
27.01	EQUITY IN EARNINGS OF UNCONOLIDATED	19,744	27.01
27.02	OTHER LOSS ON DISPOSAL	14,335	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	40,816	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	128,744	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

From 01/01/2019
To 12/31/2019Date/Time Prepared:
6/12/2020 2:36 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,623,035	0	1,623,035	-148,440	1,474,595
2.00	Physician Assistant	125,194	0	125,194	0	125,194
3.00	Nurse Practitioner	1,153,520	0	1,153,520	-19,579	1,133,941
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	1,350,317	0	1,350,317	56,032	1,406,349
10.00	Subtotal (sum of lines 1 through 9)	4,252,066	0	4,252,066	-111,987	4,140,079
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	197,208	197,208	0	197,208
13.00	Other Costs Under Agreement	0	88,086	88,086	0	88,086
14.00	Subtotal (sum of lines 11 through 13)	0	285,294	285,294	0	285,294
15.00	Medical Supplies	0	453,941	453,941	0	453,941
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	105,453	105,453	0	105,453
19.00	Other Health Care Costs	0	161,681	161,681	0	161,681
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	721,075	721,075	0	721,075
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,252,066	1,006,369	5,258,435	-111,987	5,146,448
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	94,216	94,216	0	94,216
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	94,216	94,216	0	94,216
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,252,066	1,100,585	5,352,651	-111,987	5,240,664

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

From 01/01/2019

To 12/31/2019

Date/Time Prepared:

6/12/2020 2:36 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,474,595	1.00
2.00	Physician Assistant	0	125,194	2.00
3.00	Nurse Practitioner	0	1,133,941	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	1,406,349	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,140,079	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	197,208	12.00
13.00	Other Costs Under Agreement	0	88,086	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	285,294	14.00
15.00	Medical Supplies	0	453,941	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	105,453	18.00
19.00	Other Health Care Costs	-30,553	131,128	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-30,553	690,522	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-30,553	5,115,895	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	94,216	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	94,216	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-30,553	5,210,111	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305

Period:

Worksheet M-2

Component CCN: 14-3456

From 01/01/2019
To 12/31/2019Date/Time Prepared:
6/12/2020 2:36 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	2.29	8,607	4,200	9,618		1.00
2.00	Physician Assistant	0.53	2,277	2,100	1,113		2.00
3.00	Nurse Practitioner	6.08	19,763	2,100	12,768		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.90	30,647		23,499	30,647	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.90	30,647			30,647	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)					5,115,895	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,115,895	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					94,216	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,232,710	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,326,926	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,326,926	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,326,926	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,442,821	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 6/12/2020 2:36 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)			8,442,821	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			201,481	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,241,340	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			30,647	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)			30,647	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			268.91	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)			84.70	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			268.91	268.91	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	6,436	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	1,730,705	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,730,705	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,449,912	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				84,088	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				100,372	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.)				1,194,893	16.04
16.05	Total program cost (see instructions)			0	1,295,265	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				136,717	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				245,821	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,295,265	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				70,252	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,365,517	22.00
23.00	Allowable bad debts (see instructions)				144	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				94	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				144	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)				1,365,611	26.00
26.01	Sequestration adjustment (see instructions)				27,312	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,319,713	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)				18,586	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: 14-1305 Component CCN: 14-3456	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 6/12/2020 2:36 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1.00	2.00	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		4,140,079	4,140,079	1.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0.001293	0.002935	2.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,353	12,151	3.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		76,844	27,739	4.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		82,197	39,890	5.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,115,895	5,115,895	6.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		3,326,926	3,326,926	7.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0.016067	0.007797	8.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		53,454	25,940	9.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		135,651	65,830	10.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		546	1,239	11.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		248.45	53.13	12.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		203	373	13.00
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)		50,435	19,817	14.00
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)			201,481	15.00
				70,252	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 6/12/2020 2:36 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		1,286,108	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		08/07/2019	33,605	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)		33,605	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,319,713	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		18,586	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,338,299	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00