

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

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 5:06 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/27/2020	Time: 5:06 pm
	2. ☐ Manually prepared 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 COMMUNITY HOSPITAL OF STAUNTON (14-1306) 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	-55,778	-145,158	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	-67,980	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		169,712		0	10.00
200.00	Total	0	-123,758	24,554	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: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 5:06 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 400 CALDWELL STREET			PO Box:				1.00				
2.00	City: STAUNTON			State: IL		Zip Code: 62088-1499		County: MACOUPIN				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			COMMUNITY HOSPITAL OF STAUNTON	141306	41180	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			COMMUNITY HOSPITAL OF STAUNTON-SWB	14Z306	41180		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			COMMUNITY CLINIC OF STAUNTON	148580	41180		10/20/2017	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019		12/31/2019		20.00	
21.00	Type of Control (see instructions)						2				21.00	
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3				23.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 5:06 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
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 in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 5:06 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 5:06 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			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
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00		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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
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				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:	133,857		0		118.01	
				1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 5:06 pm	
		1.00		2.00			
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	Removed and reserved					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				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 5:06 pm
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 5:06 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/29/2020	Y	04/29/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 5:06 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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	BRIAN	ENGELKE		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL OF STAUNTON			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(618) 635-4242	BENGELKE@STAUNTONHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 5:06 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.	CFO		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: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 5:06 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	11,640.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	11,640.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	11,640.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 5:06 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)	293	14	485			1.00
2.00	HMO and other (see instructions)	47	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	381	0	465			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	90			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	674	14	1,040			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			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)	674	14	1,040	0.00	104.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,778	0	5,567	0.00	9.58	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	113.94	27.00
28.00	Observation Bed Days		30	227			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 5:06 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	108	8	148	1.00
2.00 HMO and other (see instructions)			15	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	108	8	148	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1306 Component CCN: 14-8580		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 8/27/2020 5:06 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			325 N CALDWELL			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			STAUNTON IL 62088			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:30 16:30			08:30		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N			12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N			0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number						14.00		
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00		
				County		4.00			
2.00	City, State, ZIP Code, County			MACOUPIN			2.00		
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00 7.00		8.00 9.00		10.00	
Facility hours of operations (1)									
11.00	CLINIC			16:30 08:30 18:00			08:30 18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1306 Component CCN: 14-8580		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 8/27/2020 5:06 pm	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			08:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/27/2020 5:06 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)			0.492355 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,323,843		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	2,006,353		5.00
6.00	Medicaid charges	4,975,557		6.00
7.00	Medicaid cost (line 1 times line 6)	2,449,740		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,862	12,598	17,460 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,394	12,598	14,992 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	2,394	12,598	14,992 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)	1,330,934		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	190,159		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	292,553		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,038,381		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	613,646		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	628,638		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	628,638		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1306

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

Worksheet A

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,356,400	1,356,400	-50,745	1,305,655	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	433,738	433,738	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,439	141,763	196,202	1,240,132	1,436,334	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	495,641	2,520,199	3,015,840	-1,268,201	1,747,639	5.01
5.02	00550	DATA PROCESSING	208,610	50,584	259,194	-15,150	244,044	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	398,446	228,057	626,503	0	626,503	5.03
7.00	00700	OPERATION OF PLANT	165,980	493,383	659,363	5,097	664,460	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-122	40,095	39,973	0	39,973	8.00
9.00	00900	HOUSEKEEPING	216,463	21,776	238,239	0	238,239	9.00
10.00	01000	DIETARY	144,734	72,080	216,814	-125,631	91,183	10.00
11.00	01100	CAFETERIA	0	0	0	125,631	125,631	11.00
13.00	01300	NURSING ADMINISTRATION	189,963	9,335	199,298	0	199,298	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133,799	28,127	161,926	0	161,926	16.00
17.00	01700	SOCIAL SERVICE	64,583	291	64,874	0	64,874	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	73,950	73,950	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,199,522	182,360	1,381,882	-69,663	1,312,219	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	145,082	51,774	196,856	0	196,856	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	77,343	77,343	-73,950	3,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	422,961	459,279	882,240	0	882,240	54.00
60.00	06000	LABORATORY	531,239	379,010	910,249	0	910,249	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	94,312	94,312	64.00
65.00	06500	RESPIRATORY THERAPY	232,449	94,817	327,266	-13,701	313,565	65.00
66.00	06600	PHYSICAL THERAPY	49,732	672,291	722,023	24,938	746,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,759	67,759	0	67,759	67.00
68.00	06800	SPEECH PATHOLOGY	471	26,479	26,950	0	26,950	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,361	101,006	220,367	13,701	234,068	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,862	1,303,970	1,486,832	0	1,486,832	73.00
76.00	03050	CARDIAC REHAB	70,740	5,312	76,052	0	76,052	76.00
76.01	03030	BEHAVIORAL HEALTH	144,894	115,317	260,211	0	260,211	76.01
76.02	03040	WOUND CARE	-164	37,350	37,186	0	37,186	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	646,365	207,225	853,590	-28,582	825,008	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	699,794	1,664,446	2,364,240	0	2,364,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		365,540	365,540	-365,540	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,517,844	10,773,368	17,291,212	336	17,291,548	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	15,940	7,165	23,105	-336	22,769	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	6,533,784	10,780,533	17,314,317	0	17,314,317	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1306

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

Worksheet A

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-350,123	955,532	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,439	430,299	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-120,383	1,315,951	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-380,424	1,367,215	5.01
5.02	00550	DATA PROCESSING	0	244,044	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	626,503	5.03
7.00	00700	OPERATION OF PLANT	18,901	683,361	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,973	8.00
9.00	00900	HOUSEKEEPING	0	238,239	9.00
10.00	01000	DIETARY	-315	90,868	10.00
11.00	01100	CAFETERIA	-36,541	89,090	11.00
13.00	01300	NURSING ADMINISTRATION	21,495	220,793	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,657	157,269	16.00
17.00	01700	SOCIAL SERVICE	0	64,874	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	73,950	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-102,902	1,209,317	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	196,856	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-167	882,073	54.00
60.00	06000	LABORATORY	-36,176	874,073	60.00
64.00	06400	INTRAVENOUS THERAPY	0	94,312	64.00
65.00	06500	RESPIRATORY THERAPY	-1,292	312,273	65.00
66.00	06600	PHYSICAL THERAPY	0	746,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,759	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,950	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-874	233,194	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-52,253	1,434,579	73.00
76.00	03050	CARDIAC REHAB	-1,350	74,702	76.00
76.01	03030	BEHAVIORAL HEALTH	-7,800	252,411	76.01
76.02	03040	WOUND CARE	0	37,186	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	825,008	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-423,718	1,940,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,482,018	15,809,530	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,769	192.00
194.00	07950	MOB	0	0	194.00
194.01	07951	MOB	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,482,018	15,832,299	200.00

RECLASSIFICATIONS

Provider CCN: 14-1306

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 5:06 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	409,428		1.00
2.00	OPERATION OF PLANT	7.00	0	828		2.00
3.00	PHYSICAL THERAPY	66.00	0	24,938		3.00
			0	435,194		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	350,123		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,417		2.00
			0	365,540		
	D - EQUIPMENTAL RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,426		1.00
			0	2,426		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	83,865	41,766		1.00
			83,865	41,766		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,701		1.00
			0	13,701		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	31,992		1.00
	TOTALS		0	31,992		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	73,950		1.00
			0	73,950		
	K - PROPERTY TAX					
1.00	OTHER CAP REL COSTS	3.00	0	8,801		1.00
			0	8,801		
	L - OBSERVATION IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	94,312	0		1.00
			94,312	0		
	N - HOSPITALIST EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	24,649	0		1.00
			24,649	0		
	Q - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	4,269		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	4,269		
	R - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,240,132		1.00
	TOTALS		0	1,240,132		
	T - TELEPHONE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	15,150		1.00
	TOTALS		0	15,150		
500.00	Grand Total: Increases		202,826	2,232,921		500.00

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	435,194	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	435,194			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	365,540	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	365,540			
	D - EQUIPMENTAL RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,426	10		1.00
	0		0	2,426			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	83,865	41,766	0		1.00
	0		83,865	41,766			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	13,701	0		1.00
	0		0	13,701			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	31,992	12		1.00
	TOTALS		0	31,992			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	73,950	0		1.00
	0		0	73,950			
	K - PROPERTY TAX						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8,801	0		1.00
	0		0	8,801			
	L - OBSERVATION IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	94,312	0	0		1.00
	0		94,312	0			
	N - HOSPITALIST EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	24,649	0	0		1.00
	0		24,649	0			
	Q - UTILITIES						
1.00	RURAL HEALTH CLINIC	88.00	0	3,933	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	336	0		2.00
	TOTALS		0	4,269			
	R - BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,240,132	0		1.00
	TOTALS		0	1,240,132			
	T - TELEPHONE						
1.00	DATA PROCESSING	5.02	0	15,150	0		1.00
	TOTALS		0	15,150			
500.00	Grand Total: Decreases		202,826	2,232,921			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 5:06 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	546,486	0	0	0	0	1.00	
2.00	Land Improvements	2,311,375	0	0	0	12,661	2.00	
3.00	Buildings and Fixtures	8,551,579	14,939	0	14,939	109,698	3.00	
4.00	Building Improvements	8,380,957	221,693	0	221,693	17,177	4.00	
5.00	Fixed Equipment	597,891	0	0	0	421,818	5.00	
6.00	Movable Equipment	3,419,395	253,041	0	253,041	413,571	6.00	
7.00	HIT designated Assets	716,599	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	24,524,282	489,673	0	489,673	974,925	8.00	
9.00	Reconciling Items	19,937	0	0	0	16,939	9.00	
10.00	Total (line 8 minus line 9)	24,504,345	489,673	0	489,673	957,986	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	546,486	0				1.00	
2.00	Land Improvements	2,298,714	0				2.00	
3.00	Buildings and Fixtures	8,456,820	0				3.00	
4.00	Building Improvements	8,585,473	0				4.00	
5.00	Fixed Equipment	176,073	0				5.00	
6.00	Movable Equipment	3,258,865	0				6.00	
7.00	HIT designated Assets	716,599	0				7.00	
8.00	Subtotal (sum of lines 1-7)	24,039,030	0				8.00	
9.00	Reconciling Items	2,998	0				9.00	
10.00	Total (line 8 minus line 9)	24,036,032	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,356,400	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,356,400	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,356,400				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,356,400				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,887,493	0	19,887,493	0.841471	26,920	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,151,537	404,820	3,746,717	0.158529	5,072	2.00
3.00	Total (sum of lines 1-2)	24,039,030	404,820	23,634,210	1.000000	31,992	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,406	0	34,326	921,206	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,395	0	6,467	421,406	2,426	2.00
3.00	Total (sum of lines 1-2)	8,801	0	40,793	1,342,612	2,426	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	26,920	7,406	0	955,532	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,072	1,395	0	430,299	2.00
3.00	Total (sum of lines 1-2)	0	31,992	8,801	0	1,385,831	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1306

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-350,123	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-15,417	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-814	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-19,490	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	0	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,407	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,672	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-571,888			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	182,769			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-36,541	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-874	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-52,253	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,657	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1306

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 5:06 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	
30.99	Hospice (non-distinct) (see instructions)	A-8-3		0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	9
33.00	IHA LOBBYING FEES	A	-7,484	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-8,801	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02	MEDICAID PROVIDER TAX	B	-344,456	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	MISCELLANEOUS OPERATING REVENUE	B	-30,573	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	X-RAY FILM COPYING	B	-167	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	INSERVICE EDUCATION	B	-1,080	NURSING ADMINISTRATION	13.00	0	33.05
33.06	CARDIAC REHAB	B	-1,350	CARDIAC REHAB	76.00	0	33.06
33.07	DIABETIC CONSULTATION	B	-315	DIETARY	10.00	0	33.07
33.08	PUBLIC RELATIONS SALARIES	A	-9,879	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	PUBLIC RELATIONS OTHER	A	-4,227	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	PUBLIC RELATIONS BENEFITS	A	-1,868	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PHYSICIAN BENEFITS	A	-4,661	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	CHARITABLE CONTRIBUTIONS	A	-9,270	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.12
33.13	SCHOLARSHIP	A	-4,000	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.13
33.14	QUEST MISC INCOME	B	-218	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.14
33.15	DOMESTIC CLAIMS	A	-146,317	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	DEVELOPMENT ANDERSON INCOME	B	-27,985	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,482,018				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: 14-1306

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 5:06 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		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE SHARED DEPRECIAT	11,978	0
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SHARED BENEFITS	32,463	0
3.00		5.01	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE SHARED SALARIES	96,852	0
4.00		7.00	OPERATION OF PLANT	HOME OFFICE SHARED SALARIES	18,901	0
4.01		13.00	NURSING ADMINISTRATION	HOME OFFICE SHARED SALARIES	22,575	0
4.02		1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY INTEREST	74,407	74,407
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				257,176	74,407

* 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		0.00	SW IL HLTH FAC	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: 14-1306

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 5:06 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	11,978	9		1.00
2.00	32,463	0		2.00
3.00	96,852	0		3.00
4.00	18,901	0		4.00
4.01	22,575	0		4.01
4.02	0	11		4.02
5.00	182,769			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	HOSPITAL		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: 14-1306

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

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 5:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	142,402	102,902	39,500	0	0	1.00
2.00	60.00	LABORATORY	88,184	36,176	52,008	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	7,242	1,292	5,950	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	35,300	7,800	27,500	0	0	4.00
5.00	91.00	EMERGENCY	1,545,729	423,718	1,122,011	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,818,857	571,888	1,246,969		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	102,902		1.00
2.00	60.00	LABORATORY	0	0	0	36,176		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	1,292		3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	7,800		4.00
5.00	91.00	EMERGENCY	0	0	0	423,718		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	571,888		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 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)						365	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						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	1,380.50	1,890.00	4,996.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	114.04	84.48	63.36	42.24	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)	42.24	42.24	31.68			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)						157,432	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						159,667	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						316,547	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						633,646	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)						633,646	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)						633,646	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)						15,418	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)						15,418	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)						2,117	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						17,535	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)						17,535	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: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.48	63.36	42.24	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)						633,646	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						17,535	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)						651,181	63.00
64.00	Total cost of outside supplier services (from your records)						641,178	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						15,418	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,117	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						17,535	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						2,117	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						2,117	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: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 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)					365	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					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,454.50	9.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	108.10	80.08	60.06	40.04	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)					116,476	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					541	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					117,017	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)					117,017	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)					117,017	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					14,615	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,615	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)					2,117	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,732	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)					16,732	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 pm		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.08	60.06	40.04	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)						117,017	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						16,732	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)						133,749	63.00
64.00	Total cost of outside supplier services (from your records)						82,036	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						14,615	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,117	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						16,732	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						2,117	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						2,117	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: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 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)						365	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						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	431.25	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	103.88	76.95	57.71	38.47	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	28.86			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)						33,185	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)						33,185	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)						33,185	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)						14,045	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						14,045	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)						2,117	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						16,162	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)						16,162	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: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 5:06 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.95	57.71	38.47	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))						16,162	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)						76,183	63.00
64.00	Total cost of outside supplier services (from your records)						25,272	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						14,045	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,117	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						16,162	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						2,117	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						2,117	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: 14-1306

Period:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	955,532	955,532			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	430,299		430,299		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,315,951	1,696	768	1,318,415	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,367,215	75,932	34,369	99,368	1,576,884 5.01
5.02	00550	DATA PROCESSING	244,044	0	0	42,673	286,717 5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	626,503	0	0	81,507	708,010 5.03
7.00	00700	OPERATION OF PLANT	683,361	318,970	144,374	33,953	1,180,658 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,973	10,495	4,750	0	55,218 8.00
9.00	00900	HOUSEKEEPING	238,239	7,583	3,432	44,280	293,534 9.00
10.00	01000	DIETARY	90,868	23,395	10,589	12,451	137,303 10.00
11.00	01100	CAFETERIA	89,090	14,672	6,641	17,156	127,559 11.00
13.00	01300	NURSING ADMINISTRATION	220,793	3,545	1,604	38,859	264,801 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	157,269	13,748	6,223	27,370	204,610 16.00
17.00	01700	SOCIAL SERVICE	64,874	1,317	596	13,211	79,998 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	73,950	0	0	0	73,950 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,209,317	78,464	35,515	226,080	1,549,376 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	196,856	52,879	23,934	29,678	303,347 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	3,393	1,038	470	0	4,901 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	882,073	39,131	17,712	86,521	1,025,437 54.00
60.00	06000	LABORATORY	874,073	32,029	14,497	108,671	1,029,270 60.00
64.00	06400	INTRAVENOUS THERAPY	94,312	0	0	19,293	113,605 64.00
65.00	06500	RESPIRATORY THERAPY	312,273	10,507	4,756	47,550	375,086 65.00
66.00	06600	PHYSICAL THERAPY	746,961	48,043	21,746	10,173	826,923 66.00
67.00	06700	OCCUPATIONAL THERAPY	67,759	0	0	0	67,759 67.00
68.00	06800	SPEECH PATHOLOGY	26,950	3,254	1,473	96	31,773 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,194	21,445	9,707	24,417	288,763 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,434,579	10,128	4,584	37,406	1,486,697 73.00
76.00	03050	CARDIAC REHAB	74,702	13,293	6,017	14,471	108,483 76.00
76.01	03030	BEHAVIORAL HEALTH	252,411	12,533	5,673	29,640	300,257 76.01
76.02	03040	WOUND CARE	37,186	798	361	0	38,345 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	825,008	69,628	31,515	127,179	1,053,330 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,940,522	27,408	12,406	143,151	2,123,487 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,809,530	891,931	403,712	1,315,154	15,716,081 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,861	0	0	4,861 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,769	58,740	26,587	3,261	111,357 192.00
194.00	07950	MOB	0	0	0	0	0 194.00
194.01	07951	MOB	0	0	0	0	0 194.01
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	15,832,299	955,532	430,299	1,318,415	15,832,299 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	
			5.01	5A.01	5.02	5.03	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,576,884					5.01
5.02	00550	DATA PROCESSING	31,715	318,432	318,432			5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	78,317	786,327	16,140	802,467		5.03
7.00	00700	OPERATION OF PLANT	130,600	1,311,258	26,915	0	1,338,173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,108	61,326	1,259	0	25,126	8.00
9.00	00900	HOUSEKEEPING	32,470	326,004	6,692	0	18,155	9.00
10.00	01000	DIETARY	15,188	152,491	3,130	0	56,011	10.00
11.00	01100	CAFETERIA	14,110	141,669	2,908	0	35,128	11.00
13.00	01300	NURSING ADMINISTRATION	29,291	294,092	6,037	0	8,487	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,633	227,243	4,664	0	32,916	16.00
17.00	01700	SOCIAL SERVICE	8,849	88,847	1,824	0	3,152	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,180	82,130	1,686	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	171,386	1,720,762	35,320	27,370	187,856	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,555	336,902	6,915	5,689	126,601	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	542	5,443	112	2,971	2,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,430	1,138,867	23,376	225,453	93,685	54.00
60.00	06000	LABORATORY	113,854	1,143,124	23,464	207,617	76,682	60.00
64.00	06400	INTRAVENOUS THERAPY	12,567	126,172	2,590	15,043	0	64.00
65.00	06500	RESPIRATORY THERAPY	41,491	416,577	8,551	37,068	25,156	65.00
66.00	06600	PHYSICAL THERAPY	91,471	918,394	18,851	91,359	115,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,495	75,254	1,545	8,688	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,515	35,288	724	1,053	7,789	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,942	320,705	6,583	5,956	51,343	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,452	1,651,149	33,891	75,502	24,247	73.00
76.00	03050	CARDIAC REHAB	12,000	120,483	2,473	2,919	31,824	76.00
76.01	03030	BEHAVIORAL HEALTH	33,213	333,470	6,845	8,763	30,006	76.01
76.02	03040	WOUND CARE	4,242	42,587	874	1,798	1,909	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	116,515	1,169,845	24,012	0	166,700	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	234,897	2,358,384	48,401	85,218	65,619	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,564,028	15,703,225	315,782	802,467	1,185,900	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	538	5,399	111	0	11,639	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,318	123,675	2,539	0	140,634	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,576,884	15,832,299	318,432	802,467	1,338,173	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,711					8.00
9.00	00900	HOUSEKEEPING	0	350,851				9.00
10.00	01000	DIETARY	0	15,314	226,946			10.00
11.00	01100	CAFETERIA	0	9,604	0	189,309		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,320	0	7,453	318,389	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,999	0	5,249	0	16.00
17.00	01700	SOCIAL SERVICE	0	862	0	2,534	9,357	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,711	51,361	226,946	43,365	160,128	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,614	0	5,692	21,020	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	680	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,614	0	16,594	0	54.00
60.00	06000	LABORATORY	0	20,965	0	20,843	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,700	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,878	0	9,120	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,448	0	1,951	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,130	0	18	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,038	0	4,683	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,629	0	7,174	26,494	73.00
76.00	03050	CARDIAC REHAB	0	8,701	0	2,775	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	8,204	0	5,685	0	76.01
76.02	03040	WOUND CARE	0	522	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	45,577	0	24,392	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	17,941	0	27,456	101,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,711	312,401	226,946	188,684	318,389	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,450	0	625	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	87,711	350,851	226,946	189,309	318,389	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	279,071					16.00
17.00	01700	SOCIAL SERVICE	0	106,576				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	83,816			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,518	106,576	0	2,656,913	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,978	0	0	539,411	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,033	0	83,816	96,540	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,406	0	0	1,601,995	0	54.00
60.00	06000	LABORATORY	72,202	0	0	1,564,897	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,232	0	0	152,737	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,891	0	0	516,241	0	65.00
66.00	06600	PHYSICAL THERAPY	31,772	0	0	1,208,798	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,021	0	0	88,508	0	67.00
68.00	06800	SPEECH PATHOLOGY	366	0	0	47,368	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,071	0	0	405,379	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,257	0	0	1,851,343	0	73.00
76.00	03050	CARDIAC REHAB	1,015	0	0	170,190	0	76.00
76.01	03030	BEHAVIORAL HEALTH	3,048	0	0	396,021	0	76.01
76.02	03040	WOUND CARE	625	0	0	48,315	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,430,526	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	29,636	0	0	2,734,045	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	279,071	106,576	83,816	15,509,227	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,149	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	305,923	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	279,071	106,576	83,816	15,832,299	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1306

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03050	CARDIAC REHAB	76.00
76.01	03030	BEHAVIORAL HEALTH	76.01
76.02	03040	WOUND CARE	76.02
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MOB	194.00
194.01	07951	MOB	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,696	768	2,464	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	75,932	34,369	110,301	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	318,970	144,374	463,344	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,495	4,750	15,245	8.00
9.00	00900	HOUSEKEEPING	0	7,583	3,432	11,015	9.00
10.00	01000	DIETARY	0	23,395	10,589	33,984	10.00
11.00	01100	CAFETERIA	0	14,672	6,641	21,313	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,545	1,604	5,149	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,748	6,223	19,971	16.00
17.00	01700	SOCIAL SERVICE	0	1,317	596	1,913	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	78,464	35,515	113,979	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	52,879	23,934	76,813	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,038	470	1,508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,131	17,712	56,843	54.00
60.00	06000	LABORATORY	0	32,029	14,497	46,526	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,507	4,756	15,263	65.00
66.00	06600	PHYSICAL THERAPY	0	48,043	21,746	69,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,254	1,473	4,727	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,445	9,707	31,152	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,128	4,584	14,712	73.00
76.00	03050	CARDIAC REHAB	0	13,293	6,017	19,310	76.00
76.01	03030	BEHAVIORAL HEALTH	0	12,533	5,673	18,206	76.01
76.02	03040	WOUND CARE	0	798	361	1,159	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	69,628	31,515	101,143	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	27,408	12,406	39,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	891,931	403,712	1,295,643	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,861	0	4,861	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	58,740	26,587	85,327	192.00
194.00	07950	MOB	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	955,532	430,299	1,385,831	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	110,487					5.01
5.02	00550	DATA PROCESSING	2,222	2,302				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	5,488	116	5,756			5.03
7.00	00700	OPERATION OF PLANT	9,151	194	0	472,752		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	9	0	8,877	24,559	8.00
9.00	00900	HOUSEKEEPING	2,275	48	0	6,414	0	9.00
10.00	01000	DIETARY	1,064	23	0	19,788	0	10.00
11.00	01100	CAFETERIA	989	21	0	12,410	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,052	44	0	2,998	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,586	34	0	11,628	0	16.00
17.00	01700	SOCIAL SERVICE	620	13	0	1,114	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	573	12	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,009	255	196	66,365	24,559	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,351	50	41	44,726	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	38	1	21	878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,948	169	1,614	33,097	0	54.00
60.00	06000	LABORATORY	7,978	169	1,490	27,090	0	60.00
64.00	06400	INTRAVENOUS THERAPY	881	19	108	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,907	62	266	8,887	0	65.00
66.00	06600	PHYSICAL THERAPY	6,409	136	656	40,635	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	525	11	62	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	246	5	8	2,752	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,238	47	43	18,139	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,523	244	542	8,566	0	73.00
76.00	03050	CARDIAC REHAB	841	18	21	11,243	0	76.00
76.01	03030	BEHAVIORAL HEALTH	2,327	49	63	10,601	0	76.01
76.02	03040	WOUND CARE	297	6	13	675	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,164	173	0	58,892	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	16,456	355	612	23,182	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,586	2,283	5,756	418,957	24,559	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	1	0	4,112	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	863	18	0	49,683	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	110,487	2,302	5,756	472,752	24,559	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	19,835					9.00
10.00	01000	DIETARY	866	55,748				10.00
11.00	01100	CAFETERIA	543	0	35,308			11.00
13.00	01300	NURSING ADMINISTRATION	131	0	1,390	11,837		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	509	0	979	0	34,758	16.00
17.00	01700	SOCIAL SERVICE	49	0	473	348	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,902	55,748	8,086	5,954	1,185	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,957	0	1,062	781	246	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	38	0	0	0	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448	0	3,095	0	9,775	54.00
60.00	06000	LABORATORY	1,185	0	3,888	0	8,989	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	690	0	651	64.00
65.00	06500	RESPIRATORY THERAPY	389	0	1,701	0	1,605	65.00
66.00	06600	PHYSICAL THERAPY	1,778	0	364	0	3,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	376	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	3	0	46	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	794	0	873	0	258	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	375	0	1,338	985	3,269	73.00
76.00	03050	CARDIAC REHAB	492	0	518	0	126	76.00
76.01	03030	BEHAVIORAL HEALTH	464	0	1,060	0	379	76.01
76.02	03040	WOUND CARE	30	0	0	0	78	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,577	0	4,550	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,014	0	5,121	3,769	3,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,661	55,748	35,191	11,837	34,758	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	2,174	0	117	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,835	55,748	35,308	11,837	34,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,555					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	585				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,555		296,217	0	296,217	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		128,082	0	128,082	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		2,613	0	2,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		114,151	0	114,151	54.00
60.00	06000	LABORATORY	0		97,518	0	97,518	60.00
64.00	06400	INTRAVENOUS THERAPY	0		2,385	0	2,385	64.00
65.00	06500	RESPIRATORY THERAPY	0		31,169	0	31,169	65.00
66.00	06600	PHYSICAL THERAPY	0		123,742	0	123,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		974	0	974	67.00
68.00	06800	SPEECH PATHOLOGY	0		7,907	0	7,907	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		53,590	0	53,590	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		41,624	0	41,624	73.00
76.00	03050	CARDIAC REHAB	0		32,596	0	32,596	76.00
76.01	03030	BEHAVIORAL HEALTH	0		33,204	0	33,204	76.01
76.02	03040	WOUND CARE	0		2,258	0	2,258	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		175,736	0	175,736	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		94,280	0	94,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,555	0	1,238,046	0	1,238,046	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		9,012	0	9,012	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		138,188	0	138,188	192.00
194.00	07950	MOB	0		0	0	0	194.00
194.01	07951	MOB	0		0	0	0	194.01
200.00		Cross Foot Adjustments		585	585	0	585	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,555	585	1,385,831	0	1,385,831	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1306

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,479					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		75,095				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134	134	6,445,103			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5,998	5,998	485,762	-1,576,884	14,255,415	5.01
5.02	00550	DATA PROCESSING	0	0	208,610	0	286,717	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	398,446	0	708,010	5.03
7.00	00700	OPERATION OF PLANT	25,196	25,196	165,980	0	1,180,658	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	829	0	0	55,218	8.00
9.00	00900	HOUSEKEEPING	599	599	216,463	0	293,534	9.00
10.00	01000	DIETARY	1,848	1,848	60,869	0	137,303	10.00
11.00	01100	CAFETERIA	1,159	1,159	83,865	0	127,559	11.00
13.00	01300	NURSING ADMINISTRATION	280	280	189,963	0	264,801	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	1,086	133,799	0	204,610	16.00
17.00	01700	SOCIAL SERVICE	104	104	64,583	0	79,998	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	73,950	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,198	6,198	1,105,210	0	1,549,376	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,177	4,177	145,082	0	303,347	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	82	0	0	4,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	3,091	422,961	0	1,025,437	54.00
60.00	06000	LABORATORY	2,530	2,530	531,239	0	1,029,270	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	94,312	0	113,605	64.00
65.00	06500	RESPIRATORY THERAPY	830	830	232,449	0	375,086	65.00
66.00	06600	PHYSICAL THERAPY	3,795	3,795	49,732	0	826,923	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67,759	67.00
68.00	06800	SPEECH PATHOLOGY	257	257	471	0	31,773	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	1,694	119,361	0	288,763	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	800	800	182,862	0	1,486,697	73.00
76.00	03050	CARDIAC REHAB	1,050	1,050	70,740	0	108,483	76.00
76.01	03030	BEHAVIORAL HEALTH	990	990	144,894	0	300,257	76.01
76.02	03040	WOUND CARE	63	63	0	0	38,345	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,500	5,500	621,716	0	1,053,330	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,165	2,165	699,794	0	2,123,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,455	70,455	6,429,163	-1,576,884	14,139,197	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	384	0	0	0	4,861	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,640	4,640	15,940	0	111,357	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	955,532	430,299	1,318,415		1,576,884	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.659574	5.730062	0.204561		0.110616	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,464		110,487	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000382		0.007751	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: 14-1306

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5A.02	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING	-318,432	15,513,867			5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	786,327	30,802,923		5.03
7.00	00700	OPERATION OF PLANT	0	1,311,258	0	44,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,326	0	829	8.00
9.00	00900	HOUSEKEEPING	0	326,004	0	599	9.00
10.00	01000	DIETARY	0	152,491	0	1,848	10.00
11.00	01100	CAFETERIA	0	141,669	0	1,159	11.00
13.00	01300	NURSING ADMINISTRATION	0	294,092	0	280	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	227,243	0	1,086	16.00
17.00	01700	SOCIAL SERVICE	0	88,847	0	104	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	82,130	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,720,762	1,050,590	6,198	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	336,902	218,353	4,177	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	5,443	114,056	82	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,138,867	8,654,342	3,091	54.00
60.00	06000	LABORATORY	0	1,143,124	7,969,313	2,530	60.00
64.00	06400	INTRAVENOUS THERAPY	0	126,172	577,433	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	416,577	1,422,863	830	65.00
66.00	06600	PHYSICAL THERAPY	0	918,394	3,506,794	3,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,254	333,480	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,288	40,436	257	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	320,705	228,605	1,694	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,651,149	2,898,126	800	73.00
76.00	03050	CARDIAC REHAB	0	120,483	112,055	1,050	76.00
76.01	03030	BEHAVIORAL HEALTH	0	333,470	336,370	990	76.01
76.02	03040	WOUND CARE	0	42,587	69,021	63	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,169,845	0	5,500	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,358,384	3,271,086	2,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-318,432	15,384,793	30,802,923	39,127	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,399	0	384	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	123,675	0	4,640	192.00
194.00	07950	MOB	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		318,432	802,467	1,338,173	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.020526	0.026052	30.309008	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		2,302	5,756	472,752	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000148	0.000187	10.707617	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: 14-1306

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATIO N (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	42,339				9.00
10.00	01000	DIETARY	1,848	1,040			10.00
11.00	01100	CAFETERIA	1,159	0	4,825,108		11.00
13.00	01300	NURSING ADMINISTRATION	280	0	189,963	2,197,531	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	0	133,799	0	16.00
17.00	01700	SOCIAL SERVICE	104	0	64,583	64,583	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,198	1,040	1,105,210	1,105,210	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,177	0	145,082	145,082	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	0	0	114,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	0	422,961	0	54.00
60.00	06000	LABORATORY	2,530	0	531,239	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	94,312	0	64.00
65.00	06500	RESPIRATORY THERAPY	830	0	232,449	0	65.00
66.00	06600	PHYSICAL THERAPY	3,795	0	49,732	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	333,480	67.00
68.00	06800	SPEECH PATHOLOGY	257	0	471	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	0	119,361	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	800	0	182,862	182,862	73.00
76.00	03050	CARDIAC REHAB	1,050	0	70,740	0	76.00
76.01	03030	BEHAVIORAL HEALTH	990	0	144,894	0	76.01
76.02	03040	WOUND CARE	63	0	0	69,021	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,500	0	621,716	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,165	0	699,794	699,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				3,271,086	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,699	1,040	4,809,168	2,197,531	30,802,923
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,640	0	15,940	0	192.00
194.00	07950	MOB	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	350,851	226,946	189,309	318,389	279,071
203.00		Unit cost multiplier (Wkst. B, Part I)	8.286710	218.217308	0.039234	0.144885	0.009060
204.00		Cost to be allocated (per Wkst. B, Part II)	19,835	55,748	35,308	11,837	34,758
205.00		Unit cost multiplier (Wkst. B, Part II)	0.468481	53.603846	0.007318	0.005386	0.001128
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: 14-1306

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	1,040	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0 100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,040 0	30.00
31.00	03100	INTENSIVE CARE UNIT	0 0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 0	50.00
51.00	05100	RECOVERY ROOM	0 0	51.00
53.00	05300	ANESTHESIOLOGY	0 100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
64.00	06400	INTRAVENOUS THERAPY	0 0	64.00
65.00	06500	RESPIRATORY THERAPY	0 0	65.00
66.00	06600	PHYSICAL THERAPY	0 0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
68.00	06800	SPEECH PATHOLOGY	0 0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
76.00	03050	CARDIAC REHAB	0 0	76.00
76.01	03030	BEHAVIORAL HEALTH	0 0	76.01
76.02	03040	WOUND CARE	0 0	76.02
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)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,040 100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	MOB	0 0	194.00
194.01	07951	MOB	0 0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	106,576 83,816	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	102.476923 838.160000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,555 585	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.379808 5.850000	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: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 5:06 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	2,656,913		2,656,913	0
31.00	03100	INTENSIVE CARE UNIT	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	539,411		539,411	0
51.00	05100	RECOVERY ROOM	0		0	0
53.00	05300	ANESTHESIOLOGY	96,540		96,540	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,601,995		1,601,995	0
60.00	06000	LABORATORY	1,564,897		1,564,897	0
64.00	06400	INTRAVENOUS THERAPY	152,737		152,737	0
65.00	06500	RESPIRATORY THERAPY	516,241	0	516,241	0
66.00	06600	PHYSICAL THERAPY	1,208,798	0	1,208,798	0
67.00	06700	OCCUPATIONAL THERAPY	88,508	0	88,508	0
68.00	06800	SPEECH PATHOLOGY	47,368	0	47,368	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	405,379		405,379	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,851,343		1,851,343	0
76.00	03050	CARDIAC REHAB	170,190		170,190	0
76.01	03030	BEHAVIORAL HEALTH	396,021		396,021	0
76.02	03040	WOUND CARE	48,315		48,315	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,430,526		1,430,526	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	2,734,045		2,734,045	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	509,726		509,726	0
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	16,018,953	0	16,018,953	0
201.00		Less Observation Beds	509,726		509,726	0
202.00		Total (see instructions)	15,509,227	0	15,509,227	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 5:06 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	774,760		774,760		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	218,353	218,353	2.470362	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	114,056	114,056	0.846426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	318,860	8,335,482	8,654,342	0.185109	54.00
60.00	06000	LABORATORY	574,137	7,395,176	7,969,313	0.196365	60.00
64.00	06400	INTRAVENOUS THERAPY	18,466	558,967	577,433	0.264510	64.00
65.00	06500	RESPIRATORY THERAPY	188,643	1,234,220	1,422,863	0.362818	65.00
66.00	06600	PHYSICAL THERAPY	250,666	3,256,128	3,506,794	0.344702	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,046	158,434	333,480	0.265407	67.00
68.00	06800	SPEECH PATHOLOGY	6,868	33,568	40,436	1.171431	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,567	123,038	228,605	1.773273	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,135	2,625,991	2,898,126	0.638807	73.00
76.00	03050	CARDIAC REHAB	4,143	107,912	112,055	1.518808	76.00
76.01	03030	BEHAVIORAL HEALTH	0	336,370	336,370	1.177337	76.01
76.02	03040	WOUND CARE	0	69,021	69,021	0.700004	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	697,139	697,139		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	57,151	3,213,935	3,271,086	0.835822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,860	266,970	275,830	1.847972	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,755,302	28,744,760	31,500,062		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,755,302	28,744,760	31,500,062		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03050	CARDIAC REHAB	0.000000			76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000			76.01
76.02	03040	WOUND CARE	0.000000			76.02
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
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, Part I, 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	128,082	218,353	0.586582	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,613	114,056	0.022910	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,151	8,654,342	0.013190	92,098	1,215	54.00
60.00	06000	LABORATORY	97,518	7,969,313	0.012237	237,205	2,903	60.00
64.00	06400	INTRAVENOUS THERAPY	2,385	577,433	0.004130	79	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,169	1,422,863	0.021906	75,170	1,647	65.00
66.00	06600	PHYSICAL THERAPY	123,742	3,506,794	0.035286	48,033	1,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	974	333,480	0.002921	29,612	86	67.00
68.00	06800	SPEECH PATHOLOGY	7,907	40,436	0.195544	2,184	427	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,590	228,605	0.234422	40,948	9,599	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,624	2,898,126	0.014362	82,102	1,179	73.00
76.00	03050	CARDIAC REHAB	32,596	112,055	0.290893	351	102	76.00
76.01	03030	BEHAVIORAL HEALTH	33,204	336,370	0.098713	0	0	76.01
76.02	03040	WOUND CARE	2,258	69,021	0.032715	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	175,736	697,139	0.252082	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	94,280	3,271,086	0.028822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,829	275,830	0.206029	0	0	92.00
200.00		Total (lines 50 through 199)	998,658	30,725,302		607,782	18,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 5:06 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	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	83,816	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03050	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0 76.01
76.02	03040	WOUND CARE	0	0	0	0	0 76.02
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
200.00		Total (lines 50 through 199)	83,816	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 5:06 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) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	218,353	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	83,816	0	114,056	0.734867
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,654,342	0.000000
60.00	06000	LABORATORY	0	0	0	7,969,313	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	577,433	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,422,863	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	3,506,794	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	333,480	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	40,436	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	228,605	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,898,126	0.000000
76.00	03050	CARDIAC REHAB	0	0	0	112,055	0.000000
76.01	03030	BEHAVIORAL HEALTH	0	0	0	336,370	0.000000
76.02	03040	WOUND CARE	0	0	0	69,021	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	697,139	0.000000
90.00	09000	CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	3,271,086	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	275,830	0.000000
200.00		Total (lines 50 through 199)	0	83,816	0	30,725,302	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 5:06 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	92,098	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	237,205	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	79	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	75,170	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	48,033	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	29,612	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,184	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	40,948	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	82,102	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0.000000	351	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	0	0	76.02
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	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		607,782	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 5:06 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	2.470362	0	85,555	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.846426	0	39,615	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185109	0	3,163,499	0	0	54.00	
60.00	06000	LABORATORY	0.196365	0	3,087,939	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.264510	0	420,776	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.362818	0	535,866	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.344702	0	1,226,499	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.265407	0	70,472	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1.171431	0	18,093	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.773273	0	48,247	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.638807	0	1,654,105	70	0	73.00	
76.00	03050	CARDIAC REHAB	1.518808	0	76,660	0	0	76.00	
76.01	03030	BEHAVIORAL HEALTH	1.177337	0	308,795	0	0	76.01	
76.02	03040	WOUND CARE	0.700004	0	53,562	0	0	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.835822	0	755,818	125	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.847972	0	124,640	0	0	92.00	
200.00		Subtotal (see instructions)		0	11,670,141	195	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	11,670,141	195	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 5:06 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	211,352	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	33,531	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585,592	0		54.00
60.00	06000	LABORATORY	606,363	0		60.00
64.00	06400	INTRAVENOUS THERAPY	111,299	0		64.00
65.00	06500	RESPIRATORY THERAPY	194,422	0		65.00
66.00	06600	PHYSICAL THERAPY	422,777	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,704	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,195	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,555	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,056,654	45		73.00
76.00	03050	CARDIAC REHAB	116,432	0		76.00
76.01	03030	BEHAVIORAL HEALTH	363,556	0		76.01
76.02	03040	WOUND CARE	37,494	0		76.02
	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	631,729	104		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	230,331	0		92.00
200.00		Subtotal (see instructions)	4,726,986	149		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,726,986	149		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306
Component CCN: 14-Z306

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

Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	83,816	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
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
200.00		Total (lines 50 through 199)	83,816	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306
Component CCN: 14-Z306

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

Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 5:06 pm

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) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	218,353	0.000000 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000 51.00
53.00	05300	ANESTHESIOLOGY	0	83,816	0	114,056	0.734867 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,654,342	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	7,969,313	0.000000 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	577,433	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,422,863	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,506,794	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	333,480	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	40,436	0.000000 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	228,605	0.000000 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,898,126	0.000000 73.00
76.00	03050	CARDIAC REHAB	0	0	0	112,055	0.000000 76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	336,370	0.000000 76.01
76.02	03040	WOUND CARE	0	0	0	69,021	0.000000 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	697,139	0.000000 88.00
90.00	09000	CLINIC	0	0	0	0	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	3,271,086	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	275,830	0.000000 92.00
200.00		Total (lines 50 through 199)	0	83,816	0	30,725,302	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306

Period:

Worksheet D

Component CCN: 14-Z306

From 01/01/2019
To 12/31/2019

Part IV
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,565	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	66,107	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,245	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	124,542	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	88,690	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,612	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	30,818	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	46,742	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0.000000	854	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	0	0	76.02
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	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		415,175	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1306

Period:

Worksheet D

Component CCN:14-Z306

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/27/2020 5:06 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	2.470362	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.846426	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185109	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.196365	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.264510	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.362818	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.344702	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.265407	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1.171431	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.773273	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.638807	0	0	0	0	73.00	
76.00	03050	CARDIAC REHAB	1.518808	0	0	0	0	76.00	
76.01	03030	BEHAVIORAL HEALTH	1.177337	0	0	0	0	76.01	
76.02	03040	WOUND CARE	0.700004	0	0	0	0	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.835822	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.847972	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1306

Period:

Worksheet D

Component CCN:14-Z306

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/27/2020 5:06 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
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03050	CARDIAC REHAB	0	0					76.00
76.01	03030	BEHAVIORAL HEALTH	0	0					76.01
76.02	03040	WOUND CARE	0	0					76.02
	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
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 5:06 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,267	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		712	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)		485	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		465	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		90	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) (see instructions)		293	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)		381	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.23	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)		2,656,913	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)		13,971	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)		1,058,124	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,598,789	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,598,789	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,245.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		657,929	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)		657,929	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1306

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					243,487	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					901,416	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					855,532	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)					855,532	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)					227	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,245.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					509,726	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1306		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 5:06 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	296,217	2,656,913	0.111489	509,726	56,829	90.00
91.00	Nursing School cost	0	2,656,913	0.000000	509,726	0	91.00
92.00	Allied health cost	0	2,656,913	0.000000	509,726	0	92.00
93.00	All other Medical Education	0	2,656,913	0.000000	509,726	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 5:06 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		234,400		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2.470362	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.846426	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185109	92,098	17,048	54.00
60.00	06000	LABORATORY	0.196365	237,205	46,579	60.00
64.00	06400	INTRAVENOUS THERAPY	0.264510	79	21	64.00
65.00	06500	RESPIRATORY THERAPY	0.362818	75,170	27,273	65.00
66.00	06600	PHYSICAL THERAPY	0.344702	48,033	16,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265407	29,612	7,859	67.00
68.00	06800	SPEECH PATHOLOGY	1.171431	2,184	2,558	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.773273	40,948	72,612	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.638807	82,102	52,447	73.00
76.00	03050	CARDIAC REHAB	1.518808	351	533	76.00
76.01	03030	BEHAVIORAL HEALTH	1.177337	0	0	76.01
76.02	03040	WOUND CARE	0.700004	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.835822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.847972	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		607,782	243,487	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)		607,782		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1306 Component CCN: 14-Z306	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 5:06 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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2.470362	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.846426	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.185109	26,565	4,917	54.00
60.00	06000 LABORATORY	0.196365	66,107	12,981	60.00
64.00	06400 INTRAVENOUS THERAPY	0.264510	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.362818	26,245	9,522	65.00
66.00	06600 PHYSICAL THERAPY	0.344702	124,542	42,930	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.265407	88,690	23,539	67.00
68.00	06800 SPEECH PATHOLOGY	1.171431	4,612	5,403	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.773273	30,818	54,649	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.638807	46,742	29,859	73.00
76.00	03050 CARDIAC REHAB	1.518808	854	1,297	76.00
76.01	03030 BEHAVIORAL HEALTH	1.177337	0	0	76.01
76.02	03040 WOUND CARE	0.700004	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.835822	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.847972	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		415,175	185,097	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)		415,175		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 5:06 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,727,135 1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)			0 2.00
3.00	OPPI 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)			4,727,135 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)			4,774,406 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)			45,940 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,704,539 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,023,927 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,023,927 30.00
31.00	Primary payer payments			721 31.00
32.00	Subtotal (line 30 minus line 31)			3,023,206 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)			265,511 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			172,582 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			255,427 36.00
37.00	Subtotal (see instructions)			3,195,788 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)			3,195,788 40.00
40.01	Sequestration adjustment (see instructions)			63,916 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,277,030 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-145,158 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
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: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 5:06 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		638,401		3,443,994	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	08/21/2019	25,167		0	3.01
3.02		12/31/2019	212,215		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	08/21/2019	102,883	3.50
3.51			0	12/31/2019	64,081	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)		237,382		-166,964	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)		875,783		3,277,030	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		55,778		145,158	6.02
7.00	Total Medicare program liability (see instructions)		820,005		3,131,872	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: 14-1306
 Component CCN: 14-Z306

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/27/2020 5:06 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		841,413		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	08/21/2019	19,388		0	3.01
3.02		12/31/2019	227,502		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)		246,890		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)		1,088,303		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		67,980		0	6.02
7.00	Total Medicare program liability (see instructions)		1,020,323		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: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/27/2020 5:06 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: 14-1306 Component CCN: 14-Z306	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 8/27/2020 5:06 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)		864,087	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 and swing-bed pass-through, see instructions)		186,948	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		381	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)		1,051,035	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,051,035	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)		1,051,035	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		9,889	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,041,146	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)		1,041,146	0	19.00
19.01	Sequestration adjustment (see instructions)		20,823	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,088,303	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-67,980	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
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: 14-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/27/2020 5:06 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		901,416	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)		901,416	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		910,430	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)		910,430	19.00
20.00	Deductibles (exclude professional component)		90,926	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		819,504	22.00
23.00	Coinsurance		341	23.00
24.00	Subtotal (line 22 minus line 23)		819,163	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,042	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		17,577	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,586	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		836,740	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)		836,740	30.00
30.01	Sequestration adjustment (see instructions)		16,735	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		875,783	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-55,778	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
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: 14-1306

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

Worksheet G

Date/Time Prepared:
8/27/2020 5:06 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	1,435,368	0	0	0	1.00
2.00	Temporary investments	587,141	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,888,682	0	0	0	4.00
5.00	Other receivable	2,230,281	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,552,388	0	0	0	6.00
7.00	Inventory	243,126	0	0	0	7.00
8.00	Prepaid expenses	77,953	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	5,314	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,915,477	0	0	0	11.00
FIXED ASSETS						
12.00	Land	546,486	0	0	0	12.00
13.00	Land improvements	2,298,714	0	0	0	13.00
14.00	Accumulated depreciation	-765,796	0	0	0	14.00
15.00	Buildings	8,453,822	0	0	0	15.00
16.00	Accumulated depreciation	-3,797,630	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	8,761,546	0	0	0	19.00
20.00	Accumulated depreciation	-3,019,836	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	3,975,464	0	0	0	23.00
24.00	Accumulated depreciation	-3,147,122	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,998	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,308,646	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,206,034	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	157,269	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,363,303	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,587,426	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,091,111	0	0	0	37.00
38.00	Salaries, wages, and fees payable	564,273	0	0	0	38.00
39.00	Payroll taxes payable	18,654	0	0	0	39.00
40.00	Notes and loans payable (short term)	319,008	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	15,682	0	0	0	43.00
44.00	Other current liabilities	550,913	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,559,641	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	9,529,944	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	640,870	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,170,814	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,730,455	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,856,971				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)	12,856,971	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,587,426	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1306

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

Worksheet G-1

Date/Time Prepared:
8/27/2020 5:06 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		12,274,350		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		899,541				2.00
3.00	Total (sum of line 1 and line 2)		13,173,891		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,173,891		0		11.00
12.00	TRANSFERS	316,920		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)		316,920		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,856,971		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS		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: 14-1306

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 5:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	774,760		774,760	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	774,760		774,760	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	774,760		774,760	17.00
18.00	Ancillary services	1,914,531	24,804,976	26,719,507	18.00
19.00	Outpatient services	66,011	3,500,215	3,566,226	19.00
20.00	RURAL HEALTH CLINIC	0	697,139	697,139	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	76,439	1,268,500	1,344,939	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,831,741	30,270,830	33,102,571	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,314,317		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)		17,314,317		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1306

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

Worksheet G-3

Date/Time Prepared:
8/27/2020 5:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,102,571	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,044,032	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,058,539	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,314,317	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-255,778	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	361,654	6.00
7.00	Income from investments	604,714	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	814	10.00
11.00	Rebates and refunds of expenses	19,490	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	36,541	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	53,127	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	4,657	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	37,217	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	61,664	24.00
25.00	Total other income (sum of lines 6-24)	1,179,878	25.00
26.00	Total (line 5 plus line 25)	924,100	26.00
27.00	GAIN/LOSS ON ASSET	24,559	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	24,559	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	899,541	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306

Period:

Worksheet M-1

Component CCN: 14-8580

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/27/2020 5:06 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	24,485	80,000	104,485	233,826	338,311
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	16,893	0	16,893	104,775	121,668
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	12,512	0	12,512	136,560	149,072
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	53,890	80,000	133,890	475,161	609,051
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	6,927	6,927	0	6,927
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	26,446	26,446	0	26,446
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	33,373	33,373	0	33,373
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	53,890	113,373	167,263	475,161	642,424
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	38,621	38,621	-3,933	34,688
30.00	Administrative Costs	592,475	55,231	647,706	-499,810	147,896
31.00	Total Facility Overhead (sum of lines 29 and 30)	592,475	93,852	686,327	-503,743	182,584
32.00	Total facility costs (sum of lines 22, 28 and 31)	646,365	207,225	853,590	-28,582	825,008

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306

Period:

Worksheet M-1

Component CCN: 14-8580

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/27/2020 5:06 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	338,311	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	121,668	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	149,072	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	609,051	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	6,927	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	26,446	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,373	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	642,424	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	34,688	29.00
30.00	Administrative Costs	0	147,896	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	182,584	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	825,008	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1306

Period:

Worksheet M-2

Component CCN: 14-8580

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/27/2020 5:06 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.74	3,046	4,200	3,108	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.16	2,521	2,100	2,436	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.90	5,567	5,544	5,567	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.90	5,567		5,567	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)				642,424	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)				642,424	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)				182,584	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				605,518	15.00
16.00	Total overhead (sum of lines 14 and 15)				788,102	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				788,102	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				788,102	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,430,526	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/27/2020 5:06 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)		1,430,526	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		34,775	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,395,751	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,567	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)		5,567	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		250.72	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	84.70	8.00
9.00	Rate for Program covered visits (see instructions)	250.72	250.72	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,778	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	445,780	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	445,780	16.00
16.01	Total program charges (see instructions)(from contractor's records)		224,295	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,295	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,449	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.)		312,962	16.04
16.05	Total program cost (see instructions)	0	335,411	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,128	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,174	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		335,411	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		34,091	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		369,502	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		369,502	26.00
26.01	Sequestration adjustment (see instructions)		7,390	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		192,400	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)		169,712	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:14-1306 Component CCN:14-8580	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/27/2020 5:06 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		609,051	609,051	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003796	0.003796	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,312	2,312	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		9,847	1,146	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		12,159	3,458	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		642,424	642,424	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		788,102	788,102	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.018927	0.005383	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		14,916	4,242	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		27,075	7,700	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		76	45	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		356.25	171.11	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		76	41	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		27,075	7,016	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			34,775	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			34,091	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/27/2020 5:06 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		193,881	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		08/21/2019	29,644	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		12/31/2019	31,125	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)		-1,481	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		192,400	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		169,712	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		362,112	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00