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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 7:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 7:49 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 07/01/2018 and ending 12/31/2018 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-68,544	-405,906	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	-23,829	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		250,156		0	10.00
200.00	Total	0	-92,373	-155,750	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 7:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	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	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	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	BOWEN CLINIC	143456	99914		02/05/1999	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)	07/01/2018	12/31/2018	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.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 7:49 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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 7:49 pm

		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.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 7:49 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	34,629	0	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.	Y	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 7:49 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: UNITYPOINT HEALTH	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1776 WEST LAKES PARKWAY, STE 400	PO Box:		142.00
143.00	City: WEST DES MOINES	State: IA	Zip Code: 50266-8239	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	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	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017	09/30/2018	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 7:49 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.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/22/2019	Y	05/22/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 7:49 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	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 7:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 7:49 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	3,312	8,863.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		18	3,312	8,863.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		18	3,312	8,863.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	229	117	548			1.00
2.00	HMO and other (see instructions)	51	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	305	0	374			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	7			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	534	117	929			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		58	109			13.00
14.00	Total (see instructions)	534	175	1,038	0.00	159.03	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			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	3,217	0	14,921	0.00	33.17	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	192.20	27.00
28.00	Observation Bed Days		26	98			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	23	33			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

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	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	79	39	243	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	79	39	243	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 7:49 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street					1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County			IL		2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01	ADAMS STREET CLINIC					9.01
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	6	13.00

				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number			BOWEN CLINIC	143456	14.00
14.01				ADAMS STREET CLINIC	143405	14.01
14.02				LAHARPE CLINIC	148534	14.02
14.03				NAUVOO CLINIC	148547	14.03
14.04				CARTHAGE CLINIC	148571	14.04
14.05				COLCHESTER CLINIC	148572	14.05

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1305
Component CCN: 14-3456

Period:
From 07/01/2018
To 12/31/2018

Worksheet S-8

Date/Time Prepared:
5/29/2019 7:49 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				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	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 7:49 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)	0.564901	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	596,495	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	296,091	5.00
6.00	Medicaid charges	4,870,904	6.00
7.00	Medicaid cost (line 1 times line 6)	2,751,579	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,858,993	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,858,993	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)	2,412	14,662	17,074	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,363	14,662	16,025	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)	1,363	14,662	16,025	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)	558,267	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	24,663	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	37,944	27.01
28.00	Non-Medicare bad debt expense (see instructions)	520,323	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	307,212	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	323,237	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,182,230	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		716,787	716,787	-708,576	8,211	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW		0	0	854,026	854,026	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	207,360	207,360	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP		447,191	447,191	-26,804	420,387	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	40,889	40,889	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	72,480	1,366,104	1,438,584	0	1,438,584	4.00
5.01	00550	ADMINISTRATION & GENERAL	888,199	1,222,753	2,110,952	1,567	2,112,519	5.01
7.00	00700	OPERATION OF PLANT	102,667	263,228	365,895	0	365,895	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,040	29,040	0	29,040	8.00
9.00	00900	HOUSEKEEPING	78,980	20,197	99,177	0	99,177	9.00
10.00	01000	DIETARY	84,084	64,802	148,886	-68,346	80,540	10.00
11.00	01100	CAFETERIA	0	0	0	68,346	68,346	11.00
13.00	01300	NURSING ADMINISTRATION	88,889	39,297	128,186	-66,022	62,164	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,304	10,073	59,377	0	59,377	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	66,022	66,022	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	236,390	23,767	260,157	0	260,157	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	567,672	141,149	708,821	111,803	820,624	30.00
43.00	04300	NURSERY	0	0	0	127,006	127,006	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	168,214	127,952	296,166	0	296,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,779	143,594	288,373	-247,466	40,907	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	284,142	237,417	521,559	-8,389	513,170	54.00
56.00	05600	RADIOISOTOPE	0	89,572	89,572	170	89,742	56.00
60.00	06000	LABORATORY	352,455	376,909	729,364	1,010	730,374	60.00
60.02	06002	GEO PSYCH	64,679	29,339	94,018	-1,269	92,749	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	13,547	13,547	4,374	17,921	62.00
65.00	06500	RESPIRATORY THERAPY	115,845	39,844	155,689	-90,147	65,542	65.00
66.00	06600	PHYSICAL THERAPY	0	49,387	49,387	0	49,387	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,367	3,367	51,202	54,569	69.00
69.01	06901	PULMONARY REHAB	29,964	1,211	31,175	0	31,175	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,201	8,901	24,102	40,535	64,637	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,939	460,260	559,199	76,787	635,986	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,096,679	716,008	2,812,687	-30,361	2,782,326	88.00
90.00	09000	CLINIC	15,029	310,928	325,957	-59,703	266,254	90.00
91.00	09100	EMERGENCY	205,016	943,046	1,148,062	-3,636	1,144,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	45,478	2,798	48,276	-2,277	45,999	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		399,248	399,248	-399,248	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,805,085	8,297,716	14,102,801	-61,147	14,041,654	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	84,363	36,926	121,289	61,147	182,436	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	5,889,448	8,334,642	14,224,090	0	14,224,090	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	8,211		1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW	-20,640	833,386		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-14,112	193,248		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-9,453	410,934		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	40,889		2.01
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,252	1,423,332		4.00
5.01	00550	ADMINISTRATION & GENERAL	-131,281	1,981,238		5.01
7.00	00700	OPERATION OF PLANT	0	365,895		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,040		8.00
9.00	00900	HOUSEKEEPING	0	99,177		9.00
10.00	01000	DIETARY	-884	79,656		10.00
11.00	01100	CAFETERIA	-18,434	49,912		11.00
13.00	01300	NURSING ADMINISTRATION	0	62,164		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-662	58,715		16.00
17.00	01700	SOCIAL SERVICE	0	66,022		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	260,157		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	820,624		30.00
43.00	04300	NURSERY	0	127,006		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	296,166		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,907		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	513,170		54.00
56.00	05600	RADIOISOTOPE	0	89,742		56.00
60.00	06000	LABORATORY	0	730,374		60.00
60.02	06002	GEO PSYCH	-19,944	72,805		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	17,921		62.00
65.00	06500	RESPIRATORY THERAPY	0	65,542		65.00
66.00	06600	PHYSICAL THERAPY	0	49,387		66.00
69.00	06900	ELECTROCARDIOLOGY	0	54,569		69.00
69.01	06901	PULMONARY REHAB	0	31,175		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	64,637		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-203,607	432,379		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-12,817	2,769,509		88.00
90.00	09000	CLINIC	-243,996	22,258		90.00
91.00	09100	EMERGENCY	-252,594	891,832		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	45,999		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-943,676	13,097,978		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	182,436		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-943,676	13,280,414		200.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 7:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	0	532,714		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	150,076		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	23,260		3.00
	0		0	706,050		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	38,599	29,747		1.00
	0		38,599	29,747		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	7,526		1.00
2.00		0.00	0	0		2.00
	0		0	7,526		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	66,022	0		1.00
	0		66,022	0		
	E - TO RECLASS INTEREST					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,085		1.00
2.00	ADMINISTRATION & GENERAL	5.01	0	1,567		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	0	321,312		3.00
4.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	57,284		4.00
	0		0	399,248		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	60,146	56,109		1.00
2.00	NURSERY	43.00	65,708	61,298		2.00
	0		125,854	117,407		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	40,889		1.00
	0		0	40,889		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	36,764	10,364		1.00
	0		36,764	10,364		
	I - TO RECLASS NON RHC TIME					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	61,147	0		1.00
	0		61,147	0		
	J - COST CENTER MAPPING					
1.00	RADIOISOTOPE	56.00	0	170		1.00
2.00	LABORATORY	60.00	0	2,034		2.00
3.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	4,374		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,339		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	4,136		5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	40,705		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	76,825		7.00
8.00	CLINIC	90.00	0	7,843		8.00
9.00	EMERGENCY	91.00	0	1,212		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	139,638		
500.00	Grand Total: Increases		328,386	1,450,869		500.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 7:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	706,050	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	0		0	706,050			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	38,599	29,747	0		1.00
	0		38,599	29,747			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,526	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,000	11		2.00
	0		0	7,526			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	NURSING ADMINISTRATION	13.00	66,022	0	0		1.00
	0		66,022	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	399,248	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	11		4.00
	0		0	399,248			
	F - TO RECLASS ACUTE AND NURSERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	60,146	56,109	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	65,708	61,298	0		2.00
	0		125,854	117,407			
	G - MOB EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	40,889	9		1.00
	0		0	40,889			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	36,764	10,364	0		1.00
	0		36,764	10,364			
	I - TO RECLASS NON RHC TIME						
1.00	RURAL HEALTH CLINIC	88.00	61,147	0	0		1.00
	0		61,147	0			
	J - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	0	4,452	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4,205	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,389	0		3.00
4.00	LABORATORY	60.00	0	1,024	0		4.00
5.00	GEO PSYCH	60.02	0	1,269	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	45,358	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	62	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	170	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	38	0		9.00
10.00	CLINIC	90.00	0	67,546	0		10.00
11.00	EMERGENCY	91.00	0	4,848	0		11.00
12.00	DIABETIC EDUCATION	93.01	0	2,277	0		12.00
	TOTALS		0	139,638			
500.00	Grand Total: Decreases		328,386	1,450,869			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	499,957	0	0	0	0	1.00
2.00	Land Improvements	1,336,532	8,040	0	8,040	0	2.00
3.00	Buildings and Fixtures	24,941,002	89,246	0	89,246	325,824	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,028,133	139,332	0	139,332	18,089	6.00
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,774,393	236,618	0	236,618	343,913	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,774,393	236,618	0	236,618	343,913	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	499,957	0	1.00
2.00	Land Improvements	1,344,572	0	2.00
3.00	Buildings and Fixtures	24,704,424	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,149,376	0	6.00
7.00	HIT designated Assets	1,968,769	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,667,098	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,667,098	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 7:49 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	716,787	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	447,191	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,163,978	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	716,787	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	447,191	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	0	1,163,978	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 7:49 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	1,590,293	0	1,590,293	0.058389	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW	20,140,180	0	20,140,180	0.739464	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,131,697	0	5,131,697	0.188414	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	374,044	0	374,044	0.013733	0	2.01
3.00	Total (sum of lines 1-2)	27,236,214	0	27,236,214	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,211	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW	0	0	0	525,275	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	157,046	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	396,849	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	40,889	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,128,270	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	0	0	0	8,211	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW	308,111	0	0	0	833,386	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	36,202	0	0	0	193,248	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	14,085	0	0	0	410,934	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	40,889	2.01
3.00	Total (sum of lines 1-2)	358,398	0	0	0	1,486,668	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 7:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-7,439	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-742	ADMINISTRATION & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-516,534			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	282,026			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-18,434	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-662	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-884	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW		0	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 7:49 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-9,453	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
36.00	LOBBYING	A	-4,626	ADMINISTRATION & GENERAL	5.01	0	36.00
39.00	ADVERTISING - HOSPITAL	A	-47,420	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTISING- RHC	A	-8,986	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING - EMPL BEN	A	-15,252	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-13,201	NEW CAP REL COSTS-BLDG & FIXT (NEW	1.02	11	44.00
45.00	RHC SALARY REIMBURSEMENT	B	-3,831	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	AMORT OF BOND COSTS	A	6,970	CAP REL COSTS-BLDG & FIXT MOB	1.03	9	45.01
45.03	PROVIDER TAX	A	-296,091	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-30	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-21,082	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.08	PURCHASE DISCOUNTS	B	-2,574	ADMINISTRATION & GENERAL	5.01	0	45.08
45.10	MARKETING SALARIES	A	-51,849	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-9,897	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTHAGE INTEREST	A	-78	ADMINISTRATION & GENERAL	5.01	0	45.12
45.14	340B PHARMACY	A	-203,607	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-943,676				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 7:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.01	ADMINISTRATION & GENERAL	UPH A&G ADMIN AND SUPPORT SV	282,026	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			282,026	0	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		
	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		100.00	UNITYPOINT HEAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 7:49 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	282,026	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	282,026			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 7:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	25,000	0	25,000	0	0	1.00
2.00	60.02	GEO PSYCH	19,944	19,944	0	0	0	2.00
3.00	90.00	CLINIC	243,996	243,996	0	0	0	3.00
4.00	91.00	EMERGENCY	906,653	252,594	654,059	0	0	4.00
5.00	0.00		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			1,195,593	516,534	679,059		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	60.02	GEO PSYCH	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		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	60.00	LABORATORY	0	0	0	0		1.00
2.00	60.02	GEO PSYCH	0	0	0	19,944		2.00
3.00	90.00	CLINIC	0	0	0	243,996		3.00
4.00	91.00	EMERGENCY	0	0	0	252,594		4.00
5.00	0.00		0	0	0	0		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	516,534		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 7:49 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					27	1.00
2.00	Line 1 multiplied by 15 hours per week					405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.45	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	214.75	124.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.61	62.71	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.81	41.81	31.36			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)					17,955	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					7,823	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					25,778	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)					25,778	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)					75.93	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					30,752	22.00
23.00	Total salary equivalency (see instructions)					30,752	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 7:49 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.61	62.71	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	30,752	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	30,752	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 7:49 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		27	1.00
2.00	Line 1 multiplied by 15 hours per week		405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.45	7.00
8.00	Optional travel expense rate per mile		0.55	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	9.50	148.35	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.23	59.42	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.62	39.62	29.71			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)	753	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	8,815	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	9,568	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)	9,568	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)	60.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	24,547	22.00
23.00	Total salary equivalency (see instructions)	24,547	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 7:49 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.23	59.42	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		24,547	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		24,547	63.00
64.00	Total cost of outside supplier services (from your records)		0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					27	1.00
2.00	Line 1 multiplied by 15 hours per week					405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	17.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.07	38.07	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,313	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,313	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)					1,313	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)					76.12	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					30,829	22.00
23.00	Total salary equivalency (see instructions)					30,829	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 7:49 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	30,829	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	30,829	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG & FIXT (NEW	BLDG & FIXT MOB	MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,211	8,211				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW	833,386	0	833,386			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	193,248	0	0	193,248		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	410,934				410,934	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	40,889				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,423,332	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	1,981,238	2,890	212,373	76,952	106,239	5.01
7.00	00700	OPERATION OF PLANT	365,895	359	40,508	0	19,974	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	3,950	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	29,040	0	3,507	0	1,474	8.00
9.00	00900	HOUSEKEEPING	99,177	0	8,788	1,554	3,693	9.00
10.00	01000	DIETARY	79,656	0	16,612	0	6,982	10.00
11.00	01100	CAFETERIA	49,912	0	9,462	0	3,977	11.00
13.00	01300	NURSING ADMINISTRATION	62,164	0	5,107	0	2,146	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,715	885	15,166	0	13,640	16.00
17.00	01700	SOCIAL SERVICE	66,022	0	3,372	0	1,417	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	260,157	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	820,624	0	188,512	0	79,232	30.00
43.00	04300	NURSERY	127,006	0	4,336	0	1,822	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296,166	0	77,220	0	32,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,907	0	17,074	0	7,176	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	513,170	0	85,352	0	35,874	54.00
56.00	05600	RADIOISOTOPE	89,742	0	5,974	0	2,511	56.00
60.00	06000	LABORATORY	730,374	0	32,530	0	13,672	60.00
60.02	06002	GEO PSYCH	72,805	0	0	7,513	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,921	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	65,542	0	13,316	0	5,597	65.00
66.00	06600	PHYSICAL THERAPY	49,387	0	4,991	0	2,098	66.00
69.00	06900	ELECTROCARDIOLOGY	54,569	0	21,680	0	9,112	69.00
69.01	06901	PULMONARY REHAB	31,175	0	0	7,428	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,637	0	6,282	0	2,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	432,379	0	24,108	0	10,133	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,769,509	4,077	0	59,559	33,468	88.00
90.00	09000	CLINIC	22,258	0	0	0	0	90.00
91.00	09100	EMERGENCY	891,832	0	35,690	0	15,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	45,999	0	0	5,071	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,097,978	8,211	831,960	162,027	410,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,426	0	599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	182,436	0	0	31,221	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,280,414	8,211	833,386	193,248	410,934	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	4.00	4A	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	40,889					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,423,332				4.00
5.01	00550	ADMINISTRATION & GENERAL	16,281	217,331	2,613,304	2,613,304		5.01
7.00	00700	OPERATION OF PLANT	0	25,121	451,857	110,699	562,556	7.00
7.01	00701	OPERATION OF PLANT MOB	836	0	4,786	1,173	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	34,021	8,335	3,399	8.00
9.00	00900	HOUSEKEEPING	329	19,325	132,866	32,550	8,516	9.00
10.00	01000	DIETARY	0	11,130	114,380	28,022	16,098	10.00
11.00	01100	CAFETERIA	0	9,445	72,796	17,834	9,170	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,595	75,012	18,377	4,949	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,064	100,470	24,614	14,697	16.00
17.00	01700	SOCIAL SERVICE	0	16,155	86,966	21,306	3,268	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	57,842	317,999	77,906	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	118,193	1,206,561	295,592	182,681	30.00
43.00	04300	NURSERY	0	16,078	149,242	36,562	4,202	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,160	447,002	109,510	74,832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,056	105,213	25,776	16,546	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,526	703,922	172,452	82,713	54.00
56.00	05600	RADIOISOTOPE	0	0	98,227	24,064	5,789	56.00
60.00	06000	LABORATORY	0	86,241	862,817	211,379	31,524	60.00
60.02	06002	GEO PSYCH	1,590	15,826	97,734	23,944	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	17,921	4,390	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	19,350	103,805	25,431	12,905	65.00
66.00	06600	PHYSICAL THERAPY	0	0	56,476	13,836	4,837	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,996	94,357	23,116	21,010	69.00
69.01	06901	PULMONARY REHAB	1,572	7,332	47,507	11,639	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,719	77,279	18,932	6,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,209	490,829	120,247	23,363	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,602	500,237	3,379,452	827,920	0	88.00
90.00	09000	CLINIC	0	3,675	25,933	6,353	0	90.00
91.00	09100	EMERGENCY	0	50,165	992,688	243,196	34,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	1,073	11,128	63,271	15,501	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,283	1,389,899	13,024,693	2,550,656	561,174	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,025	496	1,382	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,606	33,433	253,696	62,152	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,889	1,423,332	13,280,414	2,613,304	562,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	5,959					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,755				8.00
9.00	00900	HOUSEKEEPING	82	0	174,014			9.00
10.00	01000	DIETARY	0	0	3,071	161,571		10.00
11.00	01100	CAFETERIA	0	0	1,749	0	101,549	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	944	0	1,809	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	5,999	0	2,772	16.00
17.00	01700	SOCIAL SERVICE	0	0	623	0	822	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,041	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,878	34,848	161,571	15,324	30.00
43.00	04300	NURSERY	0	0	802	0	2,249	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,473	14,275	0	6,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,156	0	648	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,742	15,778	0	10,276	54.00
56.00	05600	RADIOISOTOPE	0	0	1,104	0	0	56.00
60.00	06000	LABORATORY	0	0	6,013	0	17,456	60.00
60.02	06002	GEO PSYCH	399	0	3,463	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,462	0	3,053	65.00
66.00	06600	PHYSICAL THERAPY	0	0	923	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,008	0	1,419	69.00
69.01	06901	PULMONARY REHAB	394	0	3,423	0	1,593	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,161	0	705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,457	0	2,478	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,159	2,115	42,167	0	25,114	88.00
90.00	09000	CLINIC	0	702	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,411	6,598	0	6,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	269	0	2,337	0	1,743	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,303	45,321	159,361	161,571	101,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	264	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,656	434	14,389	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,959	45,755	174,014	161,571	101,549	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	101,091					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148,552				16.00
17.00	01700	SOCIAL SERVICE	0	0	112,985			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,716	0	0	399,662		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,973	7,435	96,037	0	2,052,900	30.00
43.00	04300	NURSERY	0	528	0	0	193,585	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,622	6,741	0	0	690,827	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,690	1,004	0	0	154,033	52.00
53.00	05300	ANESTHESIOLOGY	0	3,960	0	399,662	403,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,906	0	0	1,027,789	54.00
56.00	05600	RADIOISOTOPE	0	1,506	0	0	130,690	56.00
60.00	06000	LABORATORY	0	38,013	0	0	1,167,202	60.00
60.02	06002	GEO PSYCH	0	1,393	0	0	126,933	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	260	0	0	22,571	62.00
65.00	06500	RESPIRATORY THERAPY	7,963	2,270	0	0	157,889	65.00
66.00	06600	PHYSICAL THERAPY	0	785	0	0	76,857	66.00
69.00	06900	ELECTROCARDIOLOGY	3,703	2,237	0	0	149,850	69.00
69.01	06901	PULMONARY REHAB	0	759	0	0	65,315	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,551	0	0	105,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,465	9,560	0	0	657,399	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	23,213	0	0	4,303,140	88.00
90.00	09000	CLINIC	0	1,758	0	0	34,746	90.00
91.00	09100	EMERGENCY	17,412	9,609	16,948	0	1,335,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	4,547	64	0	0	87,732	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,091	148,552	112,985	399,662	12,943,920	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	4,167	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	332,327	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	101,091	148,552	112,985	399,662	13,280,414	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,052,900		30.00
43.00	04300	NURSERY	0	193,585		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	690,827		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	154,033		52.00
53.00	05300	ANESTHESIOLOGY	0	403,622		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,027,789		54.00
56.00	05600	RADIOISOTOPE	0	130,690		56.00
60.00	06000	LABORATORY	0	1,167,202		60.00
60.02	06002	GEO PSYCH	0	126,933		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	22,571		62.00
65.00	06500	RESPIRATORY THERAPY	0	157,889		65.00
66.00	06600	PHYSICAL THERAPY	0	76,857		66.00
69.00	06900	ELECTROCARDIOLOGY	0	149,850		69.00
69.01	06901	PULMONARY REHAB	0	65,315		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	105,716		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	657,399		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,303,140		88.00
90.00	09000	CLINIC	0	34,746		90.00
91.00	09100	EMERGENCY	0	1,335,124		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	87,732		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,943,920		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,167		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	332,327		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	13,280,414		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG & FIXT (NEW	BLDG & FIXT MOB	MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	2,890	212,373	76,952	106,239	5.01
7.00	00700	OPERATION OF PLANT	0	359	40,508	0	19,974	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	3,950	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	3,507	0	1,474	8.00
9.00	00900	HOUSEKEEPING	0	0	8,788	1,554	3,693	9.00
10.00	01000	DIETARY	0	0	16,612	0	6,982	10.00
11.00	01100	CAFETERIA	0	0	9,462	0	3,977	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,107	0	2,146	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	885	15,166	0	13,640	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,372	0	1,417	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	188,512	0	79,232	30.00
43.00	04300	NURSERY	0	0	4,336	0	1,822	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	77,220	0	32,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	17,074	0	7,176	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	85,352	0	35,874	54.00
56.00	05600	RADIOISOTOPE	0	0	5,974	0	2,511	56.00
60.00	06000	LABORATORY	0	0	32,530	0	13,672	60.00
60.02	06002	GEO PSYCH	0	0	0	7,513	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	13,316	0	5,597	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,991	0	2,098	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	21,680	0	9,112	69.00
69.01	06901	PULMONARY REHAB	0	0	0	7,428	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,282	0	2,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,108	0	10,133	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,077	0	59,559	33,468	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	35,690	0	15,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	5,071	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,211	831,960	162,027	410,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,426	0	599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	31,221	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,211	833,386	193,248	410,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	2A	4.00	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	16,281	414,735	0	414,735		5.01
7.00	00700	OPERATION OF PLANT	0	60,841	0	17,568	78,409	7.00
7.01	00701	OPERATION OF PLANT MOB	836	4,786	0	186	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,981	0	1,323	474	8.00
9.00	00900	HOUSEKEEPING	329	14,364	0	5,166	1,187	9.00
10.00	01000	DIETARY	0	23,594	0	4,447	2,244	10.00
11.00	01100	CAFETERIA	0	13,439	0	2,830	1,278	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,253	0	2,916	690	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,691	0	3,906	2,049	16.00
17.00	01700	SOCIAL SERVICE	0	4,789	0	3,381	456	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	12,364	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	267,744	0	46,911	25,459	30.00
43.00	04300	NURSERY	0	6,158	0	5,803	586	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	109,676	0	17,379	10,430	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,250	0	4,091	2,306	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,226	0	27,368	11,529	54.00
56.00	05600	RADIOISOTOPE	0	8,485	0	3,819	807	56.00
60.00	06000	LABORATORY	0	46,202	0	33,546	4,394	60.00
60.02	06002	GEO PSYCH	1,590	9,103	0	3,800	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	697	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,913	0	4,036	1,799	65.00
66.00	06600	PHYSICAL THERAPY	0	7,089	0	2,196	674	66.00
69.00	06900	ELECTROCARDIOLOGY	0	30,792	0	3,669	2,928	69.00
69.01	06901	PULMONARY REHAB	1,572	9,000	0	1,847	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,923	0	3,005	849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,241	0	19,083	3,256	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,602	109,706	0	131,391	0	88.00
90.00	09000	CLINIC	0	0	0	1,008	0	90.00
91.00	09100	EMERGENCY	0	50,691	0	38,596	4,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	1,073	6,144	0	2,460	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,283	1,446,816	0	404,792	78,216	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,025	0	79	193	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,606	37,827	0	9,864	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,889	1,486,668	0	414,735	78,409	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	4,972					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,778				8.00
9.00	00900	HOUSEKEEPING	69	0	20,786			9.00
10.00	01000	DIETARY	0	0	367	30,652		10.00
11.00	01100	CAFETERIA	0	0	209	0	17,756	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	113	0	316	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	717	0	485	16.00
17.00	01700	SOCIAL SERVICE	0	0	74	0	144	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	182	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,908	4,163	30,652	2,679	30.00
43.00	04300	NURSERY	0	0	96	0	393	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,292	1,705	0	1,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	377	0	113	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	999	1,885	0	1,797	54.00
56.00	05600	RADIOISOTOPE	0	0	132	0	0	56.00
60.00	06000	LABORATORY	0	0	718	0	3,052	60.00
60.02	06002	GEO PSYCH	333	0	414	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	294	0	534	65.00
66.00	06600	PHYSICAL THERAPY	0	0	110	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	479	0	248	69.00
69.01	06901	PULMONARY REHAB	329	0	409	0	278	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	139	0	123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	532	0	433	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,635	313	5,036	0	4,393	88.00
90.00	09000	CLINIC	0	104	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,098	788	0	1,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	224	0	279	0	305	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,590	6,714	19,036	30,652	17,756	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	31	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,382	64	1,719	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,972	6,778	20,786	30,652	17,756	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,288					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,848				16.00
17.00	01700	SOCIAL SERVICE	0	0	8,844			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	303	0	0	12,849		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,464	1,844	7,517		393,341	30.00
43.00	04300	NURSERY	0	131	0		13,167	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,856	1,672	0		146,124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189	249	0		31,575	52.00
53.00	05300	ANESTHESIOLOGY	0	982	0		982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,906	0		173,710	54.00
56.00	05600	RADIOISOTOPE	0	374	0		13,617	56.00
60.00	06000	LABORATORY	0	9,431	0		97,343	60.00
60.02	06002	GEO PSYCH	0	345	0		13,995	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	64	0		761	62.00
65.00	06500	RESPIRATORY THERAPY	889	563	0		27,028	65.00
66.00	06600	PHYSICAL THERAPY	0	195	0		10,264	66.00
69.00	06900	ELECTROCARDIOLOGY	413	555	0		39,084	69.00
69.01	06901	PULMONARY REHAB	0	188	0		12,051	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	385	0		13,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	722	2,371	0		60,638	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,758	0		259,232	88.00
90.00	09000	CLINIC	0	436	0		1,548	90.00
91.00	09100	EMERGENCY	1,944	2,383	1,327		102,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	508	16	0		9,936	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,288	36,848	8,844	0	1,420,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		2,328	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		50,856	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				12,849	12,849	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,288	36,848	8,844	12,849	1,486,668	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	393,341		30.00
43.00	04300	NURSERY	0	13,167		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	146,124		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,575		52.00
53.00	05300	ANESTHESIOLOGY	0	982		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	173,710		54.00
56.00	05600	RADIOISOTOPE	0	13,617		56.00
60.00	06000	LABORATORY	0	97,343		60.00
60.02	06002	GEO PSYCH	0	13,995		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	761		62.00
65.00	06500	RESPIRATORY THERAPY	0	27,028		65.00
66.00	06600	PHYSICAL THERAPY	0	10,264		66.00
69.00	06900	ELECTROCARDIOLOGY	0	39,084		69.00
69.01	06901	PULMONARY REHAB	0	12,051		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,424		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,638		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	259,232		88.00
90.00	09000	CLINIC	0	1,548		90.00
91.00	09100	EMERGENCY	0	102,815		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	9,936		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,420,635		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,328		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,856		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	12,849		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,486,668		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (WFMG/ADMIN SQUARE FE)	NEW BLDG & FIXT (NEW (NEW HOSP S QUARE)	BLDG & FIXT MOB (MOB SQUARE FEET)	MVBLE EQUIP (HOSP/WFMG/ ADMIN SQUA)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW	0	43,245				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				50,734		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	11,020	9,955	13,116	9,955	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	326	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,132	0	7,705	4,132	7,705	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,322	43,171	20,961	50,660	20,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,211	833,386	193,248	410,934	40,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.986662	19.271268	7.729920	8.099775	1.635560	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,816,959					4.00
5.01	00550	ADMINISTRATION & GENERAL	888,199	-2,613,304	10,667,110			5.01
7.00	00700	OPERATION OF PLANT	102,667	0	451,857	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	4,786	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	34,021	182	0	8.00
9.00	00900	HOUSEKEEPING	78,980	0	132,866	456	201	9.00
10.00	01000	DIETARY	45,485	0	114,380	862	0	10.00
11.00	01100	CAFETERIA	38,599	0	72,796	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	22,867	0	75,012	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,304	0	100,470	787	0	16.00
17.00	01700	SOCIAL SERVICE	66,022	0	86,966	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	236,390	0	317,999	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	483,039	0	1,206,561	9,782	0	30.00
43.00	04300	NURSERY	65,708	0	149,242	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	168,214	0	447,002	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,704	0	105,213	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	284,142	0	703,922	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	98,227	310	0	56.00
60.00	06000	LABORATORY	352,455	0	862,817	1,688	0	60.00
60.02	06002	GEO PSYCH	64,679	0	97,734	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	17,921	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	79,081	0	103,805	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	56,476	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	36,764	0	94,357	1,125	0	69.00
69.01	06901	PULMONARY REHAB	29,964	0	47,507	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,201	0	77,279	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,939	0	490,829	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,044,408	0	3,379,452	0	7,705	88.00
90.00	09000	CLINIC	15,020	0	25,933	0	0	90.00
91.00	09100	EMERGENCY	205,016	0	992,688	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	45,478	0	63,271	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,680,325	-2,613,304	10,411,389	30,049	10,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,025	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	136,634	0	253,696	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,423,332		2,613,304	562,556	5,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.244687		0.244987	18.675298	0.410004	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		414,735	78,409	4,972	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.038880	2.602961	0.342094	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN)	DIETARY (HOSP PATIE NT D)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	18,127					8.00
9.00	00900	HOUSEKEEPING	0	48,847				9.00
10.00	01000	DIETARY	0	862	1,038			10.00
11.00	01100	CAFETERIA	0	491	0	102,520		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	1,826	39,125	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	2,798	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	830	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,051	1,051	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,102	9,782	1,038	15,471	15,471	30.00
43.00	04300	NURSERY	0	225	0	2,271	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,130	4,007	0	6,433	6,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	654	654	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,671	4,429	0	10,374	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	17,623	0	60.00
60.02	06002	GEO PSYCH	0	972	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	3,082	3,082	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,433	1,433	69.00
69.01	06901	PULMONARY REHAB	0	961	0	1,608	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	326	0	712	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	2,502	2,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	838	11,837	0	25,353	0	88.00
90.00	09000	CLINIC	278	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,936	1,852	0	6,739	6,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	656	0	1,760	1,760	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,955	44,734	1,038	102,520	39,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	172	4,039	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	45,755	174,014	161,571	101,549	101,091	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.524135	3.562430	155.656069	0.990529	2.583796	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,778	20,786	30,652	17,756	11,288	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.373917	0.425533	29.529865	0.173195	0.288511	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 7:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,398,533				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,121,094	85	0		30.00
43.00	04300	NURSERY	79,551	0	0		43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,016,491	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	151,362	0	0		52.00
53.00	05300	ANESTHESIOLOGY	597,031	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,414,119	0	0		54.00
56.00	05600	RADIOISOTOPE	227,145	0	0		56.00
60.00	06000	LABORATORY	5,731,180	0	0		60.00
60.02	06002	GEO PSYCH	209,986	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	39,177	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	342,287	0	0		65.00
66.00	06600	PHYSICAL THERAPY	118,414	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	337,321	0	0		69.00
69.01	06901	PULMONARY REHAB	114,425	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	233,847	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,434	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,500,080	0	0		88.00
90.00	09000	CLINIC	265,073	0	0		90.00
91.00	09100	EMERGENCY	1,448,860	15	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	9,656	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,398,533	100	2,080		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0	0		194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	148,552	112,985	399,662		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006632	1,129.850000	192.145192		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,848	8,844	12,849		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001645	88.440000	6.177404		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,052,900		2,052,900	0	0	30.00
43.00	04300	NURSERY	193,585		193,585	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	690,827		690,827	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,033		154,033	0	0	52.00
53.00	05300	ANESTHESIOLOGY	403,622		403,622	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,789		1,027,789	0	0	54.00
56.00	05600	RADIOISOTOPE	130,690		130,690	0	0	56.00
60.00	06000	LABORATORY	1,167,202		1,167,202	0	0	60.00
60.02	06002	GEO PSYCH	126,933		126,933	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,571		22,571	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	157,889	0	157,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	76,857	0	76,857	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	149,850		149,850	0	0	69.00
69.01	06901	PULMONARY REHAB	65,315		65,315	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,716		105,716	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,399		657,399	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,303,140		4,303,140	0	0	88.00
90.00	09000	CLINIC	34,746		34,746	0	0	90.00
91.00	09100	EMERGENCY	1,335,124		1,335,124	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,240		197,240		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	87,732		87,732	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,141,160	0	13,141,160	0	0	200.00
201.00		Less Observation Beds	197,240		197,240		0	201.00
202.00		Total (see instructions)	12,943,920	0	12,943,920	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,121,094		1,121,094			30.00
43.00	04300	NURSERY	79,653		79,653			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,998	851,493	1,016,491	0.679619	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,197	47,165	151,362	1.017646	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,020	588,011	597,031	0.676049	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,457	5,168,662	5,414,119	0.189835	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	227,145	227,145	0.575359	0.000000	56.00
60.00	06000	LABORATORY	516,714	5,214,466	5,731,180	0.203658	0.000000	60.00
60.02	06002	GEO PSYCH	0	209,986	209,986	0.604483	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,264	18,913	39,177	0.576129	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	116,988	225,299	342,287	0.461277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	117,861	553	118,414	0.649053	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	20,397	316,924	337,321	0.444236	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	114,425	114,425	0.570811	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,818	139,029	234,847	0.450148	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	489,679	951,755	1,441,434	0.456073	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,500,080	3,500,080			88.00
90.00	09000	CLINIC	0	265,073	265,073	0.131081	0.000000	90.00
91.00	09100	EMERGENCY	40,283	1,408,577	1,448,860	0.921500	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,793	484,192	513,985	0.383747	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	9,656	9,656	9.085750	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,172,216	19,741,404	22,913,620			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,172,216	19,741,404	22,913,620			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
60.02	06002	GEO PSYCH	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,052,900		2,052,900	0	2,052,900	30.00
43.00	04300	NURSERY	193,585		193,585	0	193,585	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	690,827		690,827	0	690,827	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,033		154,033	0	154,033	52.00
53.00	05300	ANESTHESIOLOGY	403,622		403,622	0	403,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,789		1,027,789	0	1,027,789	54.00
56.00	05600	RADIOISOTOPE	130,690		130,690	0	130,690	56.00
60.00	06000	LABORATORY	1,167,202		1,167,202	0	1,167,202	60.00
60.02	06002	GEO PSYCH	126,933		126,933	0	126,933	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,571		22,571	0	22,571	62.00
65.00	06500	RESPIRATORY THERAPY	157,889	0	157,889	0	157,889	65.00
66.00	06600	PHYSICAL THERAPY	76,857	0	76,857	0	76,857	66.00
69.00	06900	ELECTROCARDIOLOGY	149,850		149,850	0	149,850	69.00
69.01	06901	PULMONARY REHAB	65,315		65,315	0	65,315	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,716		105,716	0	105,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,399		657,399	0	657,399	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,303,140		4,303,140	0	4,303,140	88.00
90.00	09000	CLINIC	34,746		34,746	0	34,746	90.00
91.00	09100	EMERGENCY	1,335,124		1,335,124	0	1,335,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,240		197,240		197,240	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	87,732		87,732	0	87,732	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,141,160	0	13,141,160	0	13,141,160	200.00
201.00		Less Observation Beds	197,240		197,240		197,240	201.00
202.00		Total (see instructions)	12,943,920	0	12,943,920	0	12,943,920	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,121,094		1,121,094			30.00
43.00	04300	NURSERY	79,653		79,653			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,998	851,493	1,016,491	0.679619	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,197	47,165	151,362	1.017646	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,020	588,011	597,031	0.676049	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,457	5,168,662	5,414,119	0.189835	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	227,145	227,145	0.575359	0.000000	56.00
60.00	06000	LABORATORY	516,714	5,214,466	5,731,180	0.203658	0.000000	60.00
60.02	06002	GEO PSYCH	0	209,986	209,986	0.604483	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,264	18,913	39,177	0.576129	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	116,988	225,299	342,287	0.461277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	117,861	553	118,414	0.649053	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	20,397	316,924	337,321	0.444236	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	114,425	114,425	0.570811	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,818	139,029	234,847	0.450148	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	489,679	951,755	1,441,434	0.456073	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,500,080	3,500,080	1.229440	0.000000	88.00
90.00	09000	CLINIC	0	265,073	265,073	0.131081	0.000000	90.00
91.00	09100	EMERGENCY	40,283	1,408,577	1,448,860	0.921500	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,793	484,192	513,985	0.383747	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	9,656	9,656	9.085750	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,172,216	19,741,404	22,913,620			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,172,216	19,741,404	22,913,620			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.679619		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.017646		52.00
53.00	05300	ANESTHESIOLOGY	0.676049		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189835		54.00
56.00	05600	RADIOISOTOPE	0.575359		56.00
60.00	06000	LABORATORY	0.203658		60.00
60.02	06002	GEO PSYCH	0.604483		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.576129		62.00
65.00	06500	RESPIRATORY THERAPY	0.461277		65.00
66.00	06600	PHYSICAL THERAPY	0.649053		66.00
69.00	06900	ELECTROCARDIOLOGY	0.444236		69.00
69.01	06901	PULMONARY REHAB	0.570811		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.450148		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.456073		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.229440		88.00
90.00	09000	CLINIC	0.131081		90.00
91.00	09100	EMERGENCY	0.921500		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383747		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	9.085750		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	690,827	146,124	544,703	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,033	31,575	122,458	0	0	52.00
53.00	05300	ANESTHESIOLOGY	403,622	982	402,640	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,789	173,710	854,079	0	0	54.00
56.00	05600	RADIOISOTOPE	130,690	13,617	117,073	0	0	56.00
60.00	06000	LABORATORY	1,167,202	97,343	1,069,859	0	0	60.00
60.02	06002	GEO PSYCH	126,933	13,995	112,938	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,571	761	21,810	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	157,889	27,028	130,861	0	0	65.00
66.00	06600	PHYSICAL THERAPY	76,857	10,264	66,593	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	149,850	39,084	110,766	0	0	69.00
69.01	06901	PULMONARY REHAB	65,315	12,051	53,264	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,716	13,424	92,292	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,399	60,638	596,761	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,303,140	259,232	4,043,908	0	0	88.00
90.00	09000	CLINIC	34,746	1,548	33,198	0	0	90.00
91.00	09100	EMERGENCY	1,335,124	102,815	1,232,309	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,240	37,792	159,448	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	87,732	9,936	77,796	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	10,894,675	1,051,919	9,842,756	0	0	200.00
201.00		Less Observation Beds	197,240	37,792	159,448	0	0	201.00
202.00		Total (line 200 minus line 201)	10,697,435	1,014,127	9,683,308	0	0	202.00

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

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	690,827	1,016,491	0.679619		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,033	151,362	1.017646		52.00
53.00	05300	ANESTHESIOLOGY	403,622	597,031	0.676049		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,789	5,414,119	0.189835		54.00
56.00	05600	RADIOISOTOPE	130,690	227,145	0.575359		56.00
60.00	06000	LABORATORY	1,167,202	5,731,180	0.203658		60.00
60.02	06002	GEO PSYCH	126,933	209,986	0.604483		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,571	39,177	0.576129		62.00
65.00	06500	RESPIRATORY THERAPY	157,889	342,287	0.461277		65.00
66.00	06600	PHYSICAL THERAPY	76,857	118,414	0.649053		66.00
69.00	06900	ELECTROCARDIOLOGY	149,850	337,321	0.444236		69.00
69.01	06901	PULMONARY REHAB	65,315	114,425	0.570811		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,716	234,847	0.450148		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,399	1,441,434	0.456073		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,303,140	3,500,080	1.229440		88.00
90.00	09000	CLINIC	34,746	265,073	0.131081		90.00
91.00	09100	EMERGENCY	1,335,124	1,448,860	0.921500		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,240	513,985	0.383747		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	87,732	9,656	9.085750		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	10,894,675	21,712,873			200.00
201.00		Less Observation Beds	197,240	0			201.00
202.00		Total (line 200 minus line 201)	10,697,435	21,712,873			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,124	1,016,491	0.143753	945	136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,575	151,362	0.208606	0	0	52.00
53.00	05300	ANESTHESIOLOGY	982	597,031	0.001645	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,710	5,414,119	0.032085	76,272	2,447	54.00
56.00	05600	RADIOISOTOPE	13,617	227,145	0.059948	0	0	56.00
60.00	06000	LABORATORY	97,343	5,731,180	0.016985	127,336	2,163	60.00
60.02	06002	GEO PSYCH	13,995	209,986	0.066647	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	761	39,177	0.019425	5,120	99	62.00
65.00	06500	RESPIRATORY THERAPY	27,028	342,287	0.078963	53,597	4,232	65.00
66.00	06600	PHYSICAL THERAPY	10,264	118,414	0.086679	726	63	66.00
69.00	06900	ELECTROCARDIOLOGY	39,084	337,321	0.115866	11,746	1,361	69.00
69.01	06901	PULMONARY REHAB	12,051	114,425	0.105318	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,424	234,847	0.057161	43,258	2,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,638	1,441,434	0.042068	118,753	4,996	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	259,232	3,500,080	0.074065	0	0	88.00
90.00	09000	CLINIC	1,548	265,073	0.005840	0	0	90.00
91.00	09100	EMERGENCY	102,815	1,448,860	0.070963	5,389	382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	37,792	513,985	0.073527	7,425	546	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9,936	9,656	1.028998	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,051,919	21,712,873		450,567	18,898	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	399,662	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	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	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	399,662	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,016,491	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	151,362	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	399,662	0	597,031	0.669416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,414,119	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	227,145	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	5,731,180	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	209,986	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	39,177	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	342,287	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	118,414	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	337,321	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	114,425	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	234,847	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,441,434	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,500,080	0.000000	88.00
90.00	09000	CLINIC	0	0	0	265,073	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,448,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	513,985	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	9,656	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	399,662	0	21,712,873		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	945	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	76,272	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	127,336	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,120	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	53,597	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	726	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,746	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	43,258	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	118,753	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,389	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,425	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		450,567	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.679619	0	297,449	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.017646	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.676049	0	162,307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189835	0	1,961,604	0	0	54.00
56.00	05600	RADIOISOTOPE	0.575359	0	135,456	0	0	56.00
60.00	06000	LABORATORY	0.203658	0	1,822,264	0	0	60.00
60.02	06002	GEO PSYCH	0.604483	0	178,979	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.576129	0	17,149	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.461277	0	105,862	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.649053	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.444236	0	176,871	0	0	69.00
69.01	06901	PULMONARY REHAB	0.570811	0	21,080	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.450148	0	23,042	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.456073	0	487,545	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.131081	0	25,276	0	0	90.00
91.00	09100	EMERGENCY	0.921500	0	366,414	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383747	0	249,927	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9.085750	0	2,228	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	6,033,453	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	6,033,453	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	202,152	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	109,727	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,381	0		54.00
56.00	05600	RADIOISOTOPE	77,936	0		56.00
60.00	06000	LABORATORY	371,119	0		60.00
60.02	06002	GEO PSYCH	108,190	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,880	0		62.00
65.00	06500	RESPIRATORY THERAPY	48,832	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	78,572	0		69.00
69.01	06901	PULMONARY REHAB	12,033	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,372	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,356	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	3,313	0		90.00
91.00	09100	EMERGENCY	337,651	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,909	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
93.01	04950	DIABETIC EDUCATION	20,243	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,080,666	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,080,666	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.679619	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.017646	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.676049	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189835	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.575359	0	0	0	0	56.00
60.00	06000	LABORATORY	0.203658	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.604483	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.576129	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.461277	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.649053	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.444236	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.570811	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.450148	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.456073	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.131081	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.921500	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383747	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9.085750	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program 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: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GEO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	393,341	144,225	249,116	646	385.63	30.00
43.00	NURSERY	13,167		13,167	109	120.80	43.00
200.00	Total (lines 30 through 199)	406,508		262,283	755		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	117	45,119	30.00
43.00	NURSERY	58	7,006	43.00
200.00	Total (lines 30 through 199)	175	52,125	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,124	1,016,491	0.143753	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,575	151,362	0.208606	0	0	52.00
53.00	05300	ANESTHESIOLOGY	982	597,031	0.001645	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,710	5,414,119	0.032085	0	0	54.00
56.00	05600	RADIOISOTOPE	13,617	227,145	0.059948	0	0	56.00
60.00	06000	LABORATORY	97,343	5,731,180	0.016985	0	0	60.00
60.02	06002	GEO PSYCH	13,995	209,986	0.066647	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	761	39,177	0.019425	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	27,028	342,287	0.078963	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,264	118,414	0.086679	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	39,084	337,321	0.115866	0	0	69.00
69.01	06901	PULMONARY REHAB	12,051	114,425	0.105318	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,424	234,847	0.057161	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,638	1,441,434	0.042068	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	259,232	3,500,080	0.074065	0	0	88.00
90.00	09000	CLINIC	1,548	265,073	0.005840	0	0	90.00
91.00	09100	EMERGENCY	102,815	1,448,860	0.070963	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	37,792	513,985	0.073527	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9,936	9,656	1.028998	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,051,919	21,712,873		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	646	0.00	117	30.00
43.00	04300	NURSERY		0	109	0.00	58	43.00
200.00		Total (lines 30 through 199)		0	755		175	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	399,662	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	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	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	399,662	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,016,491	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	151,362	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	399,662	0	597,031	0.669416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,414,119	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	227,145	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	5,731,180	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	209,986	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	39,177	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	342,287	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	118,414	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	337,321	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	114,425	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	234,847	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,441,434	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,500,080	0.000000	88.00
90.00	09000	CLINIC	0	0	0	265,073	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,448,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	513,985	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	9,656	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	399,662	0	21,712,873		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 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)	1,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	646	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)	548	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	374	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	229	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	305	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,052,900	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	752,731	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,300,169	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)	1,300,169	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)	2,012.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	460,897	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)	460,897	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	155,864	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	616,761	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	613,858	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	613,858	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)	98	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,012.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	197,240	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 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	393,341	2,052,900	0.191603	197,240	37,792	90.00
91.00	Nursing School cost	0	2,052,900	0.000000	197,240	0	91.00
92.00	Allied health cost	0	2,052,900	0.000000	197,240	0	92.00
93.00	All other Medical Education	0	2,052,900	0.000000	197,240	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

	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)	1,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	646	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)	548	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	374	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	117	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	109	15.00
16.00	Nursery days (title V or XIX only)	58	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,052,900	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	752,731	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,300,169	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)	1,300,169	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)	2,012.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	235,480	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)	235,480	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	193,585	109	1,776.01	58	103,009	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	338,489	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)	52,125	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)	52,125	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	286,364	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	98	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,012.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	197,240	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XIX | Hospital | PPS

	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	393,341	2,052,900	0.191603	197,240	37,792	90.00
91.00	Nursing School cost	0	2,052,900	0.000000	197,240	0	91.00
92.00	Allied health cost	0	2,052,900	0.000000	197,240	0	92.00
93.00	All other Medical Education	0	2,052,900	0.000000	197,240	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		350,315		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.679619	945	642	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.017646	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.676049	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189835	76,272	14,479	54.00
56.00	05600	RADIOISOTOPE	0.575359	0	0	56.00
60.00	06000	LABORATORY	0.203658	127,336	25,933	60.00
60.02	06002	GEO PSYCH	0.604483	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.576129	5,120	2,950	62.00
65.00	06500	RESPIRATORY THERAPY	0.461277	53,597	24,723	65.00
66.00	06600	PHYSICAL THERAPY	0.649053	726	471	66.00
69.00	06900	ELECTROCARDIOLOGY	0.444236	11,746	5,218	69.00
69.01	06901	PULMONARY REHAB	0.570811	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.450148	43,258	19,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.456073	118,753	54,160	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.131081	0	0	90.00
91.00	09100	EMERGENCY	0.921500	5,389	4,966	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383747	7,425	2,849	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9.085750	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		450,567	155,864	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)		450,567		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 14-Z305 | Date/Time Prepared: 5/29/2019 7:49 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.679619	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.017646	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.676049	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189835	8,661	1,644	54.00
56.00	05600	RADIOISOTOPE	0.575359	0	0	56.00
60.00	06000	LABORATORY	0.203658	52,263	10,644	60.00
60.02	06002	GEO PSYCH	0.604483	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.576129	3,037	1,750	62.00
65.00	06500	RESPIRATORY THERAPY	0.461277	26,341	12,150	65.00
66.00	06600	PHYSICAL THERAPY	0.649053	95,972	62,291	66.00
69.00	06900	ELECTROCARDIOLOGY	0.444236	633	281	69.00
69.01	06901	PULMONARY REHAB	0.570811	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.450148	25,768	11,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.456073	86,778	39,577	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.131081	0	0	90.00
91.00	09100	EMERGENCY	0.921500	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383747	1,335	512	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	9.085750	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		300,788	140,448	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)		300,788		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 7:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,080,666	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,080,666	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)	2,101,473	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)	3,733	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	849,828	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,247,912	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,247,912	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,247,912	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)	27,868	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	18,114	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,266,026	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,266,026	40.00
40.01	Sequestration adjustment (see instructions)	25,321	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,646,611	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-405,906	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 7:49 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		607,954		1,646,611	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		607,954		1,646,611	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		68,544		405,906	6.02
7.00	Total Medicare program liability (see instructions)		539,410		1,240,705	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 7:49 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		765,353		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		765,353		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		23,829		0	6.02
7.00	Total Medicare program liability (see instructions)		741,524		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 7:49 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 7:49 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)	619,997	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	141,852	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	305	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)	761,849	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	761,849	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)	761,849	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,192	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	756,657	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)	756,657	0	19.00
19.01	Sequestration adjustment (see instructions)	15,133	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	765,353	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-23,829	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 07/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 7:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	616,761	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)	616,761	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	622,929	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)	622,929	19.00
20.00	Deductibles (exclude professional component)	79,060	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	543,869	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	543,869	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,076	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	6,549	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	550,418	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)	550,418	30.00
30.01	Sequestration adjustment (see instructions)	11,008	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	607,954	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-68,544	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 7:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,043,904	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,253,615	0	0	0	4.00
5.00	Other receivable	510,704	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,249,962	0	0	0	6.00
7.00	Inventory	354,106	0	0	0	7.00
8.00	Prepaid expenses	197,481	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,109,848	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	499,957	0	0	0	12.00
13.00	Land improvements	1,344,572	0	0	0	13.00
14.00	Accumulated depreciation	-415,436	0	0	0	14.00
15.00	Buildings	27,318,198	0	0	0	15.00
16.00	Accumulated depreciation	-11,790,904	0	0	0	16.00
17.00	Leasehold improvements	23,098	0	0	0	17.00
18.00	Accumulated depreciation	-23,098	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,538,832	0	0	0	23.00
24.00	Accumulated depreciation	-6,899,639	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,595,580	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	403,456	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	7,323,489	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,726,945	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,432,373	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,850,629	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,002,458	0	0	0	38.00
39.00	Payroll taxes payable	34,697	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	15,547	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	74,217	0	0	0	43.00
44.00	Other current liabilities	833,037	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,810,585	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	58,296	0	0	0	46.00
47.00	Notes payable	21,174,798	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	421,061	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,654,155	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,464,740	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,967,633				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)	10,967,633	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,432,373	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 7:49 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		13,384,801		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,290,748				2.00
3.00	Total (sum of line 1 and line 2)		24,675,549		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)		24,675,549		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	INTERCOMPANY CONTRIBUTIONS	11,750,000		0		0	13.00
14.00	OPENING BALANCE AFFIL ENTRIES	1,957,916		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)		13,707,916		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,967,633		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2019 7:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,125,675		1,125,675	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,125,675		1,125,675	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,125,675		1,125,675	17.00
18.00	Ancillary services	2,046,261	16,670,399	18,716,660	18.00
19.00	Outpatient services	0	1,949,178	1,949,178	19.00
20.00	RURAL HEALTH CLINIC	0	3,457,190	3,457,190	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,171,936	22,076,767	25,248,703	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,224,090		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)		14,224,090		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 7:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,248,703	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,711,504	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,537,199	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,224,090	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,686,891	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	13,137	6.00
7.00	Income from investments	172,020	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	2,574	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	38,086	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	30	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	884	21.00
22.00	Rental of hospital space	20,625	22.00
23.00	Governmental appropriations	15,547	23.00
24.00	340B PHARMACY	701,781	24.00
24.01	DIRECTOR FEE REVENUE	4,968	24.01
24.02	CONTRIBUTIONS RECEIVED IN AFFILIATIO	11,750,000	24.02
25.00	Total other income (sum of lines 6-24)	12,719,652	25.00
26.00	Total (line 5 plus line 25)	11,032,761	26.00
27.00	GAIN LOSS ON ASSET DISPOSAL	-257,987	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-257,987	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,290,748	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 7:49 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	737,709	0	737,709	-61,147	676,562	1.00
2.00	Physician Assistant	62,868	0	62,868	0	62,868	2.00
3.00	Nurse Practitioner	585,463	0	585,463	0	585,463	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	710,639	0	710,639	0	710,639	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,096,679	0	2,096,679	-61,147	2,035,532	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	215,698	215,698	0	215,698	12.00
13.00	Other Costs Under Agreement	0	78,560	78,560	0	78,560	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	294,258	294,258	0	294,258	14.00
15.00	Medical Supplies	0	225,865	225,865	0	225,865	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	225,865	225,865	0	225,865	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,096,679	520,123	2,616,802	-61,147	2,555,655	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	195,885	195,885	30,786	226,671	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	195,885	195,885	30,786	226,671	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,096,679	716,008	2,812,687	-30,361	2,782,326	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 7:49 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	676,562		1.00
2.00	Physician Assistant	0	62,868		2.00
3.00	Nurse Practitioner	0	585,463		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	710,639		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,035,532		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	215,698		12.00
13.00	Other Costs Under Agreement	0	78,560		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	294,258		14.00
15.00	Medical Supplies	0	225,865		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	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	225,865		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,555,655		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-12,817	213,854		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-12,817	213,854		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-12,817	2,769,509		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 7:49 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.00	4,127	2,100	4,200		1.00
2.00	Physician Assistant	0.66	1,229	1,050	693		2.00
3.00	Nurse Practitioner	5.95	9,565	1,050	6,248		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.61	14,921		11,141	14,921	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.61	14,921			14,921	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,555,655	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,555,655	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)					213,854	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,533,631	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,747,485	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,747,485	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,747,485	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,303,140	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 7:49 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,303,140	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			114,958	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,188,182	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,921	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)			14,921	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			280.69	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	83.45	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	280.69	280.69		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,217		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	902,980		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	902,980		16.00
16.01	Total program charges (see instructions)(from contractor's records)		726,609		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,626		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		29,360		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.)		688,721		16.04
16.05	Total program cost (see instructions)	0	718,081		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,719		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		137,082		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		718,081		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		40,023		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		758,104		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)		758,104		26.00
26.01	Sequestration adjustment (see instructions)		15,162		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		492,786		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)		250,156		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 7:49 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,035,532	2,035,532	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000992	0.001857	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,019	3,780	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	39,604	22,871	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	41,623	26,651	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,555,655	2,555,655	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,747,485	1,747,485	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016287	0.010428	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,461	18,223	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	70,084	44,874	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	278	975	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	252.10	46.02	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	106	289	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	26,723	13,300	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)		114,958	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)		40,023	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 7:49 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		492,786	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		492,786	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		250,156	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		742,942	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00