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: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 3:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 3:17 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 COMMUNITY HOSPITAL OF STAUNTON (14-1306) for the cost reporting period beginning 01/01/2018 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	82,241	-147,516	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	47,992	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		93,970		0	10.00
200.00	Total	0	130,233	-53,546	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	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	COMMUNITY HOSPITAL OF STAUNTON	141306	41180	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY HOSPITAL OF STAUNTON-SWB	14Z306	41180		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	COMMUNITY CLINIC OF STAUNTON	148580	41180		10/20/2017	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	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.	3			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 pm

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

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

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 pm

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

		1.00	2.00	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:	133,857	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.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	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)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:17 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 3:17 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/12/2019	Y	04/12/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 3:17 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRIAN	ENGELKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL OF STAUNTON		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(618) 635-4242	BENGELKE@STAUNTONHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:17 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	18,264.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	18,264.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	18,264.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	563	10	757			1.00
2.00	HMO and other (see instructions)	60	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	497	0	497			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	98			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,060	10	1,352			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,060	10	1,352	0.00	106.04	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,198	0	6,977	0.00	9.81	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	115.85	27.00
28.00	Observation Bed Days		22	163			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			2			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

	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	180	4	244	1.00
2.00	HMO and other (see instructions)			17	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	180	4	244	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 3:17 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	325 N CALDWELL	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	STAUNTON	IL	62088	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	16:30	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MACOUPIN				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	18:00	08:30	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1306
Component CCN: 14-8580

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

Worksheet S-8
Date/Time Prepared:
5/29/2019 3:17 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 3:17 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)	0.502631	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,879,843	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	787,686	5.00
6.00	Medicaid charges	4,978,271	6.00
7.00	Medicaid cost (line 1 times line 6)	2,502,233	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,384	36,820	42,204	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,706	36,820	39,526	21.00
22.00	Payments received from patients for amounts previously written off as charity care	905	10,313	11,218	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,801	26,507	28,308	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,941,718	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	248,243	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	381,912	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,559,806	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	917,676	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	945,984	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	945,984	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:17 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		1,320,995	1,320,995	20,923	1,341,918	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	322,132	322,132	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	62,935	1,618,267	1,681,202	33,328	1,714,530	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	791,030	1,169,685	1,960,715	-78,066	1,882,649	5.01
5.02	00550	DATA PROCESSING	114,632	67,709	182,341	0	182,341	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	149,781	215,257	365,038	39,763	404,801	5.03
7.00	00700	OPERATION OF PLANT	174,227	538,984	713,211	828	714,039	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,423	35,113	39,536	0	39,536	8.00
9.00	00900	HOUSEKEEPING	198,165	23,800	221,965	0	221,965	9.00
10.00	01000	DIETARY	130,385	87,332	217,717	-131,153	86,564	10.00
11.00	01100	CAFETERIA	0	0	0	131,153	131,153	11.00
13.00	01300	NURSING ADMINISTRATION	238,379	15,423	253,802	0	253,802	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,336	43,947	194,283	0	194,283	16.00
17.00	01700	SOCIAL SERVICE	58,044	16	58,060	0	58,060	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	95,400	95,400	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,120,793	82,140	1,202,933	-52,249	1,150,684	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	187,291	69,051	256,342	0	256,342	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	96,550	96,550	-95,400	1,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,388	478,075	899,463	0	899,463	54.00
60.00	06000	LABORATORY	481,353	396,272	877,625	0	877,625	60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,027	4,027	70,747	74,774	64.00
65.00	06500	RESPIRATORY THERAPY	217,703	129,872	347,575	-14,942	332,633	65.00
66.00	06600	PHYSICAL THERAPY	51,110	682,211	733,321	27,294	760,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	49,290	49,290	0	49,290	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,073	17,073	3,875	20,948	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,352	77,553	181,905	14,942	196,847	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,956	1,531,192	1,740,148	0	1,740,148	73.00
76.00	03050	CARDIAC REHAB	72,874	16,522	89,396	0	89,396	76.00
76.01	03030	BEHAVIORAL HEALTH	138,108	122,804	260,912	0	260,912	76.01
76.02	03040	WOUND CARE	300	130,925	131,225	0	131,225	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	763,428	166,119	929,547	-18,498	911,049	88.00
90.00	09000	CLINIC	10,203	9,926	20,129	-3,875	16,254	90.00
91.00	09100	EMERGENCY	614,478	1,714,464	2,328,942	0	2,328,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		365,466	365,466	-365,466	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,464,674	11,276,060	17,740,734	736	17,741,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,383	1,383	-736	647	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	6,464,674	11,277,443	17,742,117	0	17,742,117	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:17 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	-99,361	1,242,557		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-56,028	266,104		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-214,800	1,499,730		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-259,267	1,623,382		5.01
5.02	00550	DATA PROCESSING	0	182,341		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	404,801		5.03
7.00	00700	OPERATION OF PLANT	22,577	736,616		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,536		8.00
9.00	00900	HOUSEKEEPING	0	221,965		9.00
10.00	01000	DIETARY	-450	86,114		10.00
11.00	01100	CAFETERIA	-33,873	97,280		11.00
13.00	01300	NURSING ADMINISTRATION	21,729	275,531		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,795	187,488		16.00
17.00	01700	SOCIAL SERVICE	0	58,060		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	95,400		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-24,948	1,125,736		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	256,342		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,150		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-80	899,383		54.00
60.00	06000	LABORATORY	-30,009	847,616		60.00
64.00	06400	INTRAVENOUS THERAPY	0	74,774		64.00
65.00	06500	RESPIRATORY THERAPY	-19,435	313,198		65.00
66.00	06600	PHYSICAL THERAPY	0	760,615		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	49,290		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,948		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-665	196,182		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,569	1,733,579		73.00
76.00	03050	CARDIAC REHAB	-460	88,936		76.00
76.01	03030	BEHAVIORAL HEALTH	0	260,912		76.01
76.02	03040	WOUND CARE	0	131,225		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	911,049		88.00
90.00	09000	CLINIC	50	16,304		90.00
91.00	09100	EMERGENCY	-416,722	1,912,220		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,125,106	16,616,364		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	647		192.00
194.00	07950	MOB	0	0		194.00
194.01	07951	MOB	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,125,106	16,617,011		200.00

RECLASSIFICATIONS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 3:17 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	314,995		1.00
2.00	OPERATION OF PLANT	7.00	0	828		2.00
3.00	PHYSICAL THERAPY	66.00	0	27,294		3.00
	0		0	343,117		
	B - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33,328		1.00
	0		0	33,328		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	361,034		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,432		2.00
	0		0	365,466		
	D - EQUIPMENTAL RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,047		1.00
	0		0	2,047		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	78,544	52,609		1.00
	0		78,544	52,609		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,942		1.00
	0		0	14,942		
	H - ADVERTISING					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	736		1.00
	TOTALS		0	736		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	95,400		1.00
	0		0	95,400		
	K - PROPERTY TAX					
1.00	OTHER CAP REL COSTS	3.00	0	3,664		1.00
	0		0	3,664		
	L - OBSERVATION IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	70,747	0		1.00
	0		70,747	0		
	N - HOSPITALIST EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	18,498	0		1.00
	0		18,498	0		
	O - AUDIOLOGIST					
1.00	SPEECH PATHOLOGY	68.00	0	3,875		1.00
	0		0	3,875		
	P - BILLING RECLASS					
1.00	BILLING, COLLECTION, & ADMITTING	5.03	0	39,763		1.00
	TOTALS		0	39,763		
500.00	Grand Total: Increases		167,789	954,947		500.00

RECLASSIFICATIONS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 3:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	343,117	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	343,117			
	B - WORKERS COMPENSATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33,328	0		1.00
	0		0	33,328			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	365,466	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	365,466			
	D - EQUIPMENTAL RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,047	10		1.00
	0		0	2,047			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	78,544	52,609	0		1.00
	0		78,544	52,609			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	14,942	0		1.00
	0		0	14,942			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	736	0		1.00
	TOTALS		0	736			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	95,400	0		1.00
	0		0	95,400			
	K - PROPERTY TAX						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,664	0		1.00
	0		0	3,664			
	L - OBSERVATION IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	70,747	0	0		1.00
	0		70,747	0			
	N - HOSPITALIST EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	18,498	0	0		1.00
	0		18,498	0			
	O - AUDIOLOGIST						
1.00	CLINIC	90.00	0	3,875	0		1.00
	0		0	3,875			
	P - BILLING RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	39,763	0		1.00
	TOTALS		0	39,763			
500.00	Grand Total: Decreases		167,789	954,947			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 3:17 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	546,486	0	0	0	0	1.00
2.00	Land Improvements	2,311,375	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,501,752	49,827	0	49,827	0	3.00
4.00	Building Improvements	7,831,644	549,313	0	549,313	0	4.00
5.00	Fixed Equipment	176,073	421,818	0	421,818	0	5.00
6.00	Movable Equipment	4,125,058	77,257	0	77,257	782,920	6.00
7.00	HIT designated Assets	716,599	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,208,987	1,098,215	0	1,098,215	782,920	8.00
9.00	Reconciling Items	0	19,937	0	19,937	0	9.00
10.00	Total (line 8 minus line 9)	24,208,987	1,078,278	0	1,078,278	782,920	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	546,486	0	1.00
2.00	Land Improvements	2,311,375	0	2.00
3.00	Buildings and Fixtures	8,551,579	0	3.00
4.00	Building Improvements	8,380,957	0	4.00
5.00	Fixed Equipment	597,891	0	5.00
6.00	Movable Equipment	3,419,395	0	6.00
7.00	HIT designated Assets	716,599	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,524,282	0	8.00
9.00	Reconciling Items	19,937	0	9.00
10.00	Total (line 8 minus line 9)	24,504,345	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 3:17 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,320,995	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,320,995	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,320,995		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,320,995		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 3:17 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	19,790,397	0	19,790,397	0.820516	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,733,885	404,820	4,329,065	0.179484	0	2.00
3.00	Total (sum of lines 1-2)	24,524,282	404,820	24,119,462	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	3,006	0	3,006	977,878	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	658	0	658	260,187	2,047	2.00
3.00	Total (sum of lines 1-2)	3,664	0	3,664	1,238,065	2,047	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	261,673	0	3,006	0	1,242,557	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,212	0	658	0	266,104	2.00
3.00	Total (sum of lines 1-2)	264,885	0	3,664	0	1,508,661	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 3:17 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)	B	-99,361	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,220	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,670	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-22,175	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	50	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,861	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,585	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-491,114			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	162,469			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-33,873	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-665	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,569	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,795	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 3:17 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	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-54,808	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	IHA LOBBYING FEES	A	-7,928	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-3,664	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02	MEDICAID PROVIDER TAX	B	-309,925	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	MISCELLANEOUS OPERATING REVENUE	B	-219	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	X-RAY FILM COPYING	B	-80	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	INSERVICE EDUCATION	B	-3,882	NURSING ADMINISTRATION	13.00	0	33.05
33.06	CARDIAC REHAB	B	-460	CARDIAC REHAB	76.00	0	33.06
33.07	DIABETIC CONSULTATION	B	-450	DIETARY	10.00	0	33.07
33.08	PUBLIC RELATIONS SALARIES	A	-10,582	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	PUBLIC RELATIONS OTHER	A	-3,128	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	PUBLIC RELATIONS BENEFITS	A	-2,511	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PHYSICIAN ADVERTISING EXPENSE	A	-736	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.11
33.12	PHYSICIAN BENEFITS	A	-4,389	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-4,075	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.13
33.14	SCHOLARSHIP	B	3,000	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.14
33.15	DOMESTIC CLAIMS	A	-207,900	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,125,106				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 3:17 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	OTHER ADMINISTRATIVE AND GEN	RELATED PARTY- ANDERSON	114,281	0	1.00
2.00	7.00	OPERATION OF PLANT	RELATED PARTY- ANDERSON	22,577	0	2.00
3.00	13.00	NURSING ADMINISTRATION	RELATED PARTY- ANDERSON	25,611	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY- ANDERSON -INT	72,161	72,161	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			234,630	72,161	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:					
6.00	B		0.00	SW IL HLTH FAC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 3:17 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	114,281	0		1.00
2.00	22,577	0		2.00
3.00	25,611	0		3.00
4.00	0	11		4.00
5.00	162,469			5.00

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

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

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

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

6.00	HOSPITAL		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 3:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	64,948	24,948	40,000	0	0	1.00
2.00	60.00	LABORATORY	82,017	30,009	52,008	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	22,385	19,435	2,950	0	0	3.00
4.00	76.00	CARDIAC REHAB	750	0	750	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	30,070	0	30,070	0	0	5.00
6.00	91.00	EMERGENCY	1,536,818	416,722	1,120,096	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			1,736,988	491,114	1,245,874		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	76.00	CARDIAC REHAB	0	0	0	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	24,948		1.00
2.00	60.00	LABORATORY	0	0	0	30,009		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	19,435		3.00
4.00	76.00	CARDIAC REHAB	0	0	0	0		4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	416,722		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	491,114		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 3:17 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,692.50	1,920.50	4,895.50	145.00	0.00	9.00
10.00	AHSEA (see instructions)	111.33	82.46	61.85	41.23	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)	41.23	41.23	30.93			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)					188,426	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					158,364	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					302,787	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					649,577	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					5,978	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)					655,555	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					655,555	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					15,049	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					15,049	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,281	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					17,330	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					17,330	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 3:17 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)	82.46	61.85	41.23	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)	655,555	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	17,330	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)	672,885	63.00	
64.00	Total cost of outside supplier services (from your records)	664,860	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	15,049	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,281	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	17,330	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,281	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	2,281	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 3:17 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		126	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)		106	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		6.25	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	148.25	601.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	105.53	78.17	58.63	39.08	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)	39.09	39.09	29.32			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)	11,589	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	35,281	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	46,870	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)	46,870	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)	62.49	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	48,742	22.00
23.00	Total salary equivalency (see instructions)	48,742	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)	4,925	24.00
25.00	Assistants (line 4 times column 3, line 11)	3,108	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,033	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)	1,450	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,483	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)	9,483	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 3:17 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)	78.17	58.63	39.08	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)		48,742	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		9,483	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)		58,225	63.00
64.00	Total cost of outside supplier services (from your records)		49,290	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		8,033	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,450	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		9,483	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		1,450	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		1,450	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 3:17 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					96	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					6.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	260.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	101.40	75.11	56.34	37.56	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)	37.56	37.56	28.17			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)					19,529	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)					19,529	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)					19,529	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)					75.11	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					29,293	22.00
23.00	Total salary equivalency (see instructions)					29,293	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)					3,606	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)					3,606	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)					600	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,206	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)					4,206	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2019 3:17 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)	75.11	56.34	37.56	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)	29,293		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,206		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)	33,499		63.00
64.00	Total cost of outside supplier services (from your records)	20,948		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	3,606		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	600		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,206		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	600		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	600		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,242,557	1,242,557				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	266,104		266,104			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,499,730	2,192	472	1,502,394		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,623,382	98,117	21,119	183,995	1,926,613	5.01
5.02	00550	DATA PROCESSING	182,341	0	0	27,025	209,366	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	404,801	0	0	35,312	440,113	5.03
7.00	00700	OPERATION OF PLANT	736,616	412,164	88,716	41,075	1,278,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,536	13,561	2,919	1,043	57,059	8.00
9.00	00900	HOUSEKEEPING	221,965	9,799	2,109	46,719	280,592	9.00
10.00	01000	DIETARY	86,114	33,076	7,120	12,222	138,532	10.00
11.00	01100	CAFETERIA	97,280	16,113	3,468	18,517	135,378	11.00
13.00	01300	NURSING ADMINISTRATION	275,531	4,580	986	56,199	337,296	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,488	17,765	3,824	35,443	244,520	16.00
17.00	01700	SOCIAL SERVICE	58,060	1,701	366	13,684	73,811	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	95,400	0	0	0	95,400	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,125,736	101,388	21,824	247,555	1,496,503	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,342	68,328	14,707	44,155	383,532	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,150	1,341	289	0	2,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,383	50,563	10,884	99,345	1,060,175	54.00
60.00	06000	LABORATORY	847,616	41,386	8,908	113,482	1,011,392	60.00
64.00	06400	INTRAVENOUS THERAPY	74,774	0	0	16,679	91,453	64.00
65.00	06500	RESPIRATORY THERAPY	313,198	13,577	2,922	51,325	381,022	65.00
66.00	06600	PHYSICAL THERAPY	760,615	62,080	13,362	12,049	848,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,290	0	0	0	49,290	67.00
68.00	06800	SPEECH PATHOLOGY	20,948	0	0	0	20,948	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	196,182	27,711	5,965	24,602	254,460	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,733,579	13,087	2,817	49,263	1,798,746	73.00
76.00	03050	CARDIAC REHAB	88,936	17,176	3,697	17,180	126,989	76.00
76.01	03030	BEHAVIORAL HEALTH	260,912	16,195	3,486	32,560	313,153	76.01
76.02	03040	WOUND CARE	131,225	1,031	222	71	132,549	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	911,049	89,970	19,366	175,622	1,196,007	88.00
90.00	09000	CLINIC	16,304	4,204	905	2,405	23,818	90.00
91.00	09100	EMERGENCY	1,912,220	35,416	7,623	144,867	2,100,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,616,364	1,152,521	248,076	1,502,394	16,508,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,282	0	0	6,282	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	647	83,754	18,028	0	102,429	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,617,011	1,242,557	266,104	1,502,394	16,617,011	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	
			5.01	5A.01	5.02	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,926,613					5.01
5.02	00550	DATA PROCESSING	27,458	236,824	236,824			5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	57,720	497,833	7,198	505,031		5.03
7.00	00700	OPERATION OF PLANT	167,682	1,446,253	20,910	0	1,467,163	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,483	64,542	933	0	28,477	8.00
9.00	00900	HOUSEKEEPING	36,799	317,391	4,589	0	20,576	9.00
10.00	01000	DIETARY	18,168	156,700	2,266	0	69,458	10.00
11.00	01100	CAFETERIA	17,755	153,133	2,214	0	33,836	11.00
13.00	01300	NURSING ADMINISTRATION	44,236	381,532	5,516	0	9,618	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,068	276,588	3,999	0	37,305	16.00
17.00	01700	SOCIAL SERVICE	9,680	83,491	1,207	0	3,572	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	12,512	107,912	1,560	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	196,263	1,692,766	24,474	17,758	212,908	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,299	433,831	6,272	4,424	143,484	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	365	3,145	45	2,010	2,817	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,040	1,199,215	17,338	139,823	106,179	54.00
60.00	06000	LABORATORY	132,642	1,144,034	16,540	127,500	86,908	60.00
64.00	06400	INTRAVENOUS THERAPY	11,994	103,447	1,496	7,053	0	64.00
65.00	06500	RESPIRATORY THERAPY	49,970	430,992	6,231	25,133	28,511	65.00
66.00	06600	PHYSICAL THERAPY	111,227	959,333	13,870	54,993	130,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,464	55,754	806	3,315	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,747	23,695	343	487	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,372	287,832	4,161	3,807	58,190	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,902	2,034,648	29,417	58,548	27,481	73.00
76.00	03050	CARDIAC REHAB	16,654	143,643	2,077	1,987	36,068	76.00
76.01	03030	BEHAVIORAL HEALTH	41,069	354,222	5,121	6,981	34,007	76.01
76.02	03040	WOUND CARE	17,384	149,933	2,168	3,450	2,164	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	156,854	1,352,861	19,560	0	188,930	88.00
90.00	09000	CLINIC	3,124	26,942	390	0	8,828	90.00
91.00	09100	EMERGENCY	275,425	2,375,551	34,345	47,762	74,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,912,356	16,494,043	235,046	505,031	1,344,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	824	7,106	103	0	13,191	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,433	115,862	1,675	0	109,923	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,926,613	16,617,011	236,824	505,031	1,467,163	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	93,952					8.00
9.00	00900	HOUSEKEEPING	0	342,556				9.00
10.00	01000	DIETARY	0	16,936	245,360			10.00
11.00	01100	CAFETERIA	0	8,250	0	197,433		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,345	0	9,763	408,774	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,096	0	6,157	0	16.00
17.00	01700	SOCIAL SERVICE	0	871	0	2,377	11,198	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,952	51,912	245,360	43,007	202,581	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,985	0	7,671	36,133	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	687	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,889	0	17,258	0	54.00
60.00	06000	LABORATORY	0	21,190	0	19,714	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,898	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,952	0	8,916	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,786	0	2,093	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,188	0	4,274	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,701	0	8,558	40,313	73.00
76.00	03050	CARDIAC REHAB	0	8,794	0	2,985	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	8,292	0	5,656	0	76.01
76.02	03040	WOUND CARE	0	528	0	12	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	46,066	0	30,509	0	88.00
90.00	09000	CLINIC	0	2,153	0	418	0	90.00
91.00	09100	EMERGENCY	0	18,133	0	25,167	118,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,952	315,754	245,360	197,433	408,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,802	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,952	342,556	245,360	197,433	408,774	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,145					16.00
17.00	01700	SOCIAL SERVICE	0	102,716				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	109,472			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,714	102,716	0	2,699,148	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,918	0	0	669,718	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,326	0	109,472	119,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,233	0	0	1,597,935	0	54.00
60.00	06000	LABORATORY	84,106	0	0	1,499,992	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,653	0	0	119,547	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,579	0	0	523,314	0	65.00
66.00	06600	PHYSICAL THERAPY	36,277	0	0	1,228,714	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,187	0	0	62,062	0	67.00
68.00	06800	SPEECH PATHOLOGY	321	0	0	24,846	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,511	0	0	374,963	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,621	0	0	2,244,287	0	73.00
76.00	03050	CARDIAC REHAB	1,311	0	0	196,865	0	76.00
76.01	03030	BEHAVIORAL HEALTH	4,605	0	0	418,884	0	76.01
76.02	03040	WOUND CARE	2,276	0	0	160,531	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,637,926	0	88.00
90.00	09000	CLINIC	0	0	0	38,731	0	90.00
91.00	09100	EMERGENCY	31,507	0	0	2,725,384	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,145	102,716	109,472	16,342,349	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	20,400	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	254,262	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	333,145	102,716	109,472	16,617,011	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,699,148		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	669,718		50.00
51.00	05100	RECOVERY ROOM	0		51.00
53.00	05300	ANESTHESIOLOGY	119,502		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,597,935		54.00
60.00	06000	LABORATORY	1,499,992		60.00
64.00	06400	INTRAVENOUS THERAPY	119,547		64.00
65.00	06500	RESPIRATORY THERAPY	523,314		65.00
66.00	06600	PHYSICAL THERAPY	1,228,714		66.00
67.00	06700	OCCUPATIONAL THERAPY	62,062		67.00
68.00	06800	SPEECH PATHOLOGY	24,846		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,963		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,244,287		73.00
76.00	03050	CARDIAC REHAB	196,865		76.00
76.01	03030	BEHAVIORAL HEALTH	418,884		76.01
76.02	03040	WOUND CARE	160,531		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,637,926		88.00
90.00	09000	CLINIC	38,731		90.00
91.00	09100	EMERGENCY	2,725,384		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,342,349		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,400		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	254,262		192.00
194.00	07950	MOB	0		194.00
194.01	07951	MOB	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	16,617,011		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,192	472	2,664	2,664	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	98,117	21,119	119,236	326	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	48	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	63	5.03
7.00	00700	OPERATION OF PLANT	0	412,164	88,716	500,880	73	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,561	2,919	16,480	2	8.00
9.00	00900	HOUSEKEEPING	0	9,799	2,109	11,908	83	9.00
10.00	01000	DIETARY	0	33,076	7,120	40,196	22	10.00
11.00	01100	CAFETERIA	0	16,113	3,468	19,581	33	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,580	986	5,566	100	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,765	3,824	21,589	63	16.00
17.00	01700	SOCIAL SERVICE	0	1,701	366	2,067	24	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	101,388	21,824	123,212	439	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,328	14,707	83,035	78	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,341	289	1,630	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,563	10,884	61,447	176	54.00
60.00	06000	LABORATORY	0	41,386	8,908	50,294	201	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	30	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,577	2,922	16,499	91	65.00
66.00	06600	PHYSICAL THERAPY	0	62,080	13,362	75,442	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,711	5,965	33,676	44	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,087	2,817	15,904	87	73.00
76.00	03050	CARDIAC REHAB	0	17,176	3,697	20,873	30	76.00
76.01	03030	BEHAVIORAL HEALTH	0	16,195	3,486	19,681	58	76.01
76.02	03040	WOUND CARE	0	1,031	222	1,253	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	89,970	19,366	109,336	311	88.00
90.00	09000	CLINIC	0	4,204	905	5,109	4	90.00
91.00	09100	EMERGENCY	0	35,416	7,623	43,039	257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,152,521	248,076	1,400,597	2,664	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,282	0	6,282	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	83,754	18,028	101,782	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,242,557	266,104	1,508,661	2,664	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	119,562					5.01
5.02	00550	DATA PROCESSING	1,704	1,752				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	3,582	53	3,698			5.03
7.00	00700	OPERATION OF PLANT	10,406	155	0	511,514		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	464	7	0	9,928	26,881	8.00
9.00	00900	HOUSEKEEPING	2,284	34	0	7,174	0	9.00
10.00	01000	DIETARY	1,128	17	0	24,216	0	10.00
11.00	01100	CAFETERIA	1,102	16	0	11,797	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,745	41	0	3,353	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,990	30	0	13,006	0	16.00
17.00	01700	SOCIAL SERVICE	601	9	0	1,246	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	776	12	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,180	181	130	74,228	26,881	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,122	46	32	50,024	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	23	0	15	982	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,629	128	1,022	37,018	0	54.00
60.00	06000	LABORATORY	8,232	122	934	30,300	0	60.00
64.00	06400	INTRAVENOUS THERAPY	744	11	52	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,101	46	184	9,940	0	65.00
66.00	06600	PHYSICAL THERAPY	6,903	103	403	45,450	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	401	6	24	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	170	3	4	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,071	31	28	20,288	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,640	218	429	9,581	0	73.00
76.00	03050	CARDIAC REHAB	1,034	15	15	12,575	0	76.00
76.01	03030	BEHAVIORAL HEALTH	2,549	38	51	11,856	0	76.01
76.02	03040	WOUND CARE	1,079	16	25	754	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,734	145	0	65,869	0	88.00
90.00	09000	CLINIC	194	3	0	3,078	0	90.00
91.00	09100	EMERGENCY	17,089	253	350	25,928	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,677	1,739	3,698	468,591	26,881	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51	1	0	4,599	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	834	12	0	38,324	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	119,562	1,752	3,698	511,514	26,881	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	21,483					9.00
10.00	01000	DIETARY	1,062	66,641				10.00
11.00	01100	CAFETERIA	517	0	33,046			11.00
13.00	01300	NURSING ADMINISTRATION	147	0	1,634	13,586		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	570	0	1,031	0	38,279	16.00
17.00	01700	SOCIAL SERVICE	55	0	398	372	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	3,256	66,641	7,199	6,733	1,346	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,194	0	1,284	1,201	335	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	43	0	0	0	152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,624	0	2,889	0	10,594	54.00
60.00	06000	LABORATORY	1,329	0	3,300	0	9,665	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	485	0	535	64.00
65.00	06500	RESPIRATORY THERAPY	436	0	1,492	0	1,905	65.00
66.00	06600	PHYSICAL THERAPY	1,993	0	350	0	4,169	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	251	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	37	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	890	0	715	0	289	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	420	0	1,432	1,340	4,438	73.00
76.00	03050	CARDIAC REHAB	552	0	500	0	151	76.00
76.01	03030	BEHAVIORAL HEALTH	520	0	947	0	529	76.01
76.02	03040	WOUND CARE	33	0	2	0	262	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,889	0	5,106	0	0	88.00
90.00	09000	CLINIC	135	0	70	0	0	90.00
91.00	09100	EMERGENCY	1,137	0	4,212	3,940	3,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,802	66,641	33,046	13,586	38,279	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	1,681	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,483	66,641	33,046	13,586	38,279	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,772					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	788				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,772		327,198	0	327,198	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		141,351	0	141,351	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		2,845	0	2,845	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		123,527	0	123,527	54.00
60.00	06000	LABORATORY	0		104,377	0	104,377	60.00
64.00	06400	INTRAVENOUS THERAPY	0		1,857	0	1,857	64.00
65.00	06500	RESPIRATORY THERAPY	0		33,694	0	33,694	65.00
66.00	06600	PHYSICAL THERAPY	0		134,834	0	134,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		682	0	682	67.00
68.00	06800	SPEECH PATHOLOGY	0		214	0	214	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		58,032	0	58,032	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		48,489	0	48,489	73.00
76.00	03050	CARDIAC REHAB	0		35,745	0	35,745	76.00
76.01	03030	BEHAVIORAL HEALTH	0		36,229	0	36,229	76.01
76.02	03040	WOUND CARE	0		3,424	0	3,424	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		193,390	0	193,390	88.00
90.00	09000	CLINIC	0		8,593	0	8,593	90.00
91.00	09100	EMERGENCY	0		99,826	0	99,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,772	0	1,354,307	0	1,354,307	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		10,933	0	10,933	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		142,633	0	142,633	192.00
194.00	07950	MOB	0		0	0	0	194.00
194.01	07951	MOB	0		0	0	0	194.01
200.00		Cross Foot Adjustments		788	788	0	788	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,772	788	1,508,661	0	1,508,661	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,959					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		75,575				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134	134	6,372,659			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5,998	5,998	780,448	-1,926,613	14,690,398	5.01
5.02	00550	DATA PROCESSING	0	0	114,632	0	209,366	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	149,781	0	440,113	5.03
7.00	00700	OPERATION OF PLANT	25,196	25,196	174,227	0	1,278,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	829	4,423	0	57,059	8.00
9.00	00900	HOUSEKEEPING	599	599	198,165	0	280,592	9.00
10.00	01000	DIETARY	2,022	2,022	51,841	0	138,532	10.00
11.00	01100	CAFETERIA	985	985	78,544	0	135,378	11.00
13.00	01300	NURSING ADMINISTRATION	280	280	238,379	0	337,296	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	1,086	150,336	0	244,520	16.00
17.00	01700	SOCIAL SERVICE	104	104	58,044	0	73,811	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	95,400	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,198	6,198	1,050,046	0	1,496,503	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,177	4,177	187,291	0	383,532	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	82	0	0	2,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	3,091	421,388	0	1,060,175	54.00
60.00	06000	LABORATORY	2,530	2,530	481,353	0	1,011,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	70,747	0	91,453	64.00
65.00	06500	RESPIRATORY THERAPY	830	830	217,703	0	381,022	65.00
66.00	06600	PHYSICAL THERAPY	3,795	3,795	51,110	0	848,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	49,290	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	20,948	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	1,694	104,352	0	254,460	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	800	800	208,956	0	1,798,746	73.00
76.00	03050	CARDIAC REHAB	1,050	1,050	72,874	0	126,989	76.00
76.01	03030	BEHAVIORAL HEALTH	990	990	138,108	0	313,153	76.01
76.02	03040	WOUND CARE	63	63	300	0	132,549	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,500	5,500	744,930	0	1,196,007	88.00
90.00	09000	CLINIC	257	257	10,203	0	23,818	90.00
91.00	09100	EMERGENCY	2,165	2,165	614,478	0	2,100,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,455	70,455	6,372,659	-1,926,613	14,581,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	384	0	0	0	6,282	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,120	5,120	0	0	102,429	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,242,557	266,104	1,502,394		1,926,613	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.358259	3.521059	0.235756		0.131148	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,664		119,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000418		0.008139	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5A.02	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING	-236,824	16,380,187				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	497,833	31,613,785			5.03
7.00	00700	OPERATION OF PLANT	0	1,446,253	0	42,711		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,542	0	829	1,356	8.00
9.00	00900	HOUSEKEEPING	0	317,391	0	599	0	9.00
10.00	01000	DIETARY	0	156,700	0	2,022	0	10.00
11.00	01100	CAFETERIA	0	153,133	0	985	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	381,532	0	280	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	276,588	0	1,086	0	16.00
17.00	01700	SOCIAL SERVICE	0	83,491	0	104	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	107,912	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,692,766	1,111,610	6,198	1,356	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	433,831	276,916	4,177	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,145	125,799	82	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,199,215	8,752,599	3,091	0	54.00
60.00	06000	LABORATORY	0	1,144,034	7,981,200	2,530	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	103,447	441,506	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	430,992	1,573,297	830	0	65.00
66.00	06600	PHYSICAL THERAPY	0	959,333	3,442,456	3,795	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	55,754	207,494	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,695	30,458	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	287,832	238,302	1,694	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,034,648	3,664,963	800	0	73.00
76.00	03050	CARDIAC REHAB	0	143,643	124,381	1,050	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	354,222	436,995	990	0	76.01
76.02	03040	WOUND CARE	0	149,933	215,991	63	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,352,861	0	5,500	0	88.00
90.00	09000	CLINIC	0	26,942	0	257	0	90.00
91.00	09100	EMERGENCY	0	2,375,551	2,989,818	2,165	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-236,824	16,257,219	31,613,785	39,127	1,356	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,106	0	384	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115,862	0	3,200	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		236,824	505,031	1,467,163	93,952	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.014458	0.015975	34.350940	69.286136	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,752	3,698	511,514	26,881	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000107	0.000117	11.976165	19.823746	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	40,899					9.00
10.00	01000	DIETARY	2,022	1,356				10.00
11.00	01100	CAFETERIA	985	0	4,820,598			11.00
13.00	01300	NURSING ADMINISTRATION	280	0	238,379	2,118,815		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	0	150,336	0	31,613,785	16.00
17.00	01700	SOCIAL SERVICE	104	0	58,044	58,044	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,198	1,356	1,050,046	1,050,046	1,111,610	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,177	0	187,291	187,291	276,916	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	0	0	0	125,799	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	0	421,388	0	8,752,599	54.00
60.00	06000	LABORATORY	2,530	0	481,353	0	7,981,200	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	70,747	0	441,506	64.00
65.00	06500	RESPIRATORY THERAPY	830	0	217,703	0	1,573,297	65.00
66.00	06600	PHYSICAL THERAPY	3,795	0	51,110	0	3,442,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	207,494	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	30,458	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	0	104,352	0	238,302	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	800	0	208,956	208,956	3,664,963	73.00
76.00	03050	CARDIAC REHAB	1,050	0	72,874	0	124,381	76.00
76.01	03030	BEHAVIORAL HEALTH	990	0	138,108	0	436,995	76.01
76.02	03040	WOUND CARE	63	0	300	0	215,991	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,500	0	744,930	0	0	88.00
90.00	09000	CLINIC	257	0	10,203	0	0	90.00
91.00	09100	EMERGENCY	2,165	0	614,478	614,478	2,989,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,699	1,356	4,820,598	2,118,815	31,613,785	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	3,200	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	342,556	245,360	197,433	408,774	333,145	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.375657	180.943953	0.040956	0.192926	0.010538	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,483	66,641	33,046	13,586	38,279	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.525270	49.145280	0.006855	0.006412	0.001211	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:17 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,356			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,356	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03050	CARDIAC REHAB	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	0		76.01
76.02	03040	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,356	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MOB	0	0		194.00
194.01	07951	MOB	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	102,716	109,472		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	75.749263	1,094.720000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,772	788		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.519174	7.880000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:17 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	2,699,148		2,699,148	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	669,718		669,718	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	119,502		119,502	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,597,935		1,597,935	0	0	54.00
60.00	06000	LABORATORY	1,499,992		1,499,992	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	119,547		119,547	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	523,314	0	523,314	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,228,714	0	1,228,714	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,062	0	62,062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,846	0	24,846	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,963		374,963	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,244,287		2,244,287	0	0	73.00
76.00	03050	CARDIAC REHAB	196,865		196,865	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	418,884		418,884	0	0	76.01
76.02	03040	WOUND CARE	160,531		160,531	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,637,926		1,637,926	0	0	88.00
90.00	09000	CLINIC	38,731		38,731	0	0	90.00
91.00	09100	EMERGENCY	2,725,384		2,725,384	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	310,487		310,487		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,652,836	0	16,652,836	0	0	200.00
201.00		Less Observation Beds	310,487		310,487		0	201.00
202.00		Total (see instructions)	16,342,349	0	16,342,349	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:17 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	915,840		915,840			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	276,916	276,916	2.418488	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	125,799	125,799	0.949944	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	269,511	8,483,088	8,752,599	0.182567	0.000000	54.00
60.00	06000	LABORATORY	607,697	7,373,503	7,981,200	0.187941	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,701	439,805	441,506	0.270771	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	193,474	1,379,823	1,573,297	0.332623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	301,471	3,140,985	3,442,456	0.356929	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,812	85,682	207,494	0.299103	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,423	27,035	30,458	0.815746	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,021	139,281	238,302	1.573478	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	307,259	3,357,704	3,664,963	0.612363	0.000000	73.00
76.00	03050	CARDIAC REHAB	6,892	117,489	124,381	1.582758	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0	436,995	436,995	0.958556	0.000000	76.01
76.02	03040	WOUND CARE	0	215,991	215,991	0.743230	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,572	891,572			88.00
90.00	09000	CLINIC	0	8,270	8,270	4.683313	0.000000	90.00
91.00	09100	EMERGENCY	5,575	2,984,243	2,989,818	0.911555	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,770	195,770	1.585978	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,833,676	29,679,951	32,513,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,833,676	29,679,951	32,513,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:17 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03050	CARDIAC REHAB	0.000000		76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000		76.01
76.02	03040	WOUND CARE	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 3:17 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	141,351	276,916	0.510447	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,845	125,799	0.022615	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,527	8,752,599	0.014113	160,598	2,267	54.00
60.00	06000	LABORATORY	104,377	7,981,200	0.013078	362,606	4,742	60.00
64.00	06400	INTRAVENOUS THERAPY	1,857	441,506	0.004206	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,694	1,573,297	0.021416	111,137	2,380	65.00
66.00	06600	PHYSICAL THERAPY	134,834	3,442,456	0.039168	86,899	3,404	66.00
67.00	06700	OCCUPATIONAL THERAPY	682	207,494	0.003287	30,666	101	67.00
68.00	06800	SPEECH PATHOLOGY	214	30,458	0.007026	1,713	12	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,032	238,302	0.243523	51,242	12,479	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,489	3,664,963	0.013230	167,215	2,212	73.00
76.00	03050	CARDIAC REHAB	35,745	124,381	0.287383	350	101	76.00
76.01	03030	BEHAVIORAL HEALTH	36,229	436,995	0.082905	0	0	76.01
76.02	03040	WOUND CARE	3,424	215,991	0.015853	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	193,390	891,572	0.216909	0	0	88.00
90.00	09000	CLINIC	8,593	8,270	1.039057	0	0	90.00
91.00	09100	EMERGENCY	99,826	2,989,818	0.033389	2,411	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,638	195,770	0.192256	0	0	92.00
200.00		Total (lines 50 through 199)	1,064,747	31,597,787		974,837	27,779	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 3:17 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	109,472	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	109,472	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:17 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	276,916	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	109,472	0	125,799	0.870214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,752,599	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,981,200	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	441,506	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,573,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,442,456	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	207,494	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	30,458	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	238,302	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,664,963	0.000000	73.00
76.00	03050	CARDIAC REHAB	0	0	0	124,381	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	436,995	0.000000	76.01
76.02	03040	WOUND CARE	0	0	0	215,991	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	891,572	0.000000	88.00
90.00	09000	CLINIC	0	0	0	8,270	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,989,818	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	195,770	0.000000	92.00
200.00		Total (lines 50 through 199)	0	109,472	0	31,597,787		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 3:17 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	160,598	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	362,606	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	111,137	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	86,899	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	30,666	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,713	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	51,242	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	167,215	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0.000000	350	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,411	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		974,837	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:17 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	2.418488	0	110,160	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.949944	0	51,520	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182567	0	3,385,992	0	0	54.00
60.00	06000	LABORATORY	0.187941	0	3,300,755	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.270771	0	288,090	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	0	690,821	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.356929	0	1,193,543	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.299103	0	53,710	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.815746	0	7,748	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573478	0	64,926	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.612363	0	2,625,908	0	0	73.00
76.00	03050	CARDIAC REHAB	1.582758	0	80,659	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.958556	0	378,430	0	0	76.01
76.02	03040	WOUND CARE	0.743230	0	106,634	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	4.683313	0	2,709	0	0	90.00
91.00	09100	EMERGENCY	0.911555	0	981,932	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.585978	0	94,765	0	0	92.00
200.00		Subtotal (see instructions)		0	13,418,302	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	13,418,302	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:17 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	266,421	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	48,941	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,170	0		54.00
60.00	06000	LABORATORY	620,347	0		60.00
64.00	06400	INTRAVENOUS THERAPY	78,006	0		64.00
65.00	06500	RESPIRATORY THERAPY	229,783	0		65.00
66.00	06600	PHYSICAL THERAPY	426,010	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,065	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,320	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,160	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,608,009	0		73.00
76.00	03050	CARDIAC REHAB	127,664	0		76.00
76.01	03030	BEHAVIORAL HEALTH	362,746	0		76.01
76.02	03040	WOUND CARE	79,254	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	12,687	0		90.00
91.00	09100	EMERGENCY	895,085	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	150,295	0		92.00
200.00		Subtotal (see instructions)	5,647,963	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,647,963	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 3:17 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	2.418488	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.949944	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182567	0	0	0	0	54.00
60.00	06000	LABORATORY	0.187941	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.270771	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.356929	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.299103	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.815746	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573478	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.612363	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	1.582758	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.958556	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.743230	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	4.683313	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.911555	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.585978	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 3:17 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
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	76.01
76.02	03040	WOUND CARE	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:17 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)	1,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	920	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)	757	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	497	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	98	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	563	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)	497	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	2,699,148	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)	946,701	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,752,447	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)	1,752,447	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,904.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,072,419	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,072,419	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:17 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	361,798	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,434,217	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)	946,701	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)	946,701	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)	163	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,904.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	310,487	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:17 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	327,198	2,699,148	0.121223	310,487	37,638	90.00
91.00	Nursing School cost	0	2,699,148	0.000000	310,487	0	91.00
92.00	Allied health cost	0	2,699,148	0.000000	310,487	0	92.00
93.00	All other Medical Education	0	2,699,148	0.000000	310,487	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 3:17 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		450,400		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.418488	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.949944	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182567	160,598	29,320	54.00
60.00	06000	LABORATORY	0.187941	362,606	68,149	60.00
64.00	06400	INTRAVENOUS THERAPY	0.270771	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	111,137	36,967	65.00
66.00	06600	PHYSICAL THERAPY	0.356929	86,899	31,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.299103	30,666	9,172	67.00
68.00	06800	SPEECH PATHOLOGY	0.815746	1,713	1,397	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573478	51,242	80,628	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.612363	167,215	102,396	73.00
76.00	03050	CARDIAC REHAB	1.582758	350	554	76.00
76.01	03030	BEHAVIORAL HEALTH	0.958556	0	0	76.01
76.02	03040	WOUND CARE	0.743230	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	4.683313	0	0	90.00
91.00	09100	EMERGENCY	0.911555	2,411	2,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.585978	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		974,837	361,798	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)		974,837		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 14-Z306 | Date/Time Prepared: 5/29/2019 3:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.418488	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.949944	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182567	31,325	5,719	54.00
60.00	06000	LABORATORY	0.187941	84,213	15,827	60.00
64.00	06400	INTRAVENOUS THERAPY	0.270771	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.332623	37,725	12,548	65.00
66.00	06600	PHYSICAL THERAPY	0.356929	149,822	53,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.299103	66,346	19,844	67.00
68.00	06800	SPEECH PATHOLOGY	0.815746	711	580	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573478	29,664	46,676	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.612363	88,677	54,303	73.00
76.00	03050	CARDIAC REHAB	1.582758	1,961	3,104	76.00
76.01	03030	BEHAVIORAL HEALTH	0.958556	0	0	76.01
76.02	03040	WOUND CARE	0.743230	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	4.683313	0	0	90.00
91.00	09100	EMERGENCY	0.911555	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.585978	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		490,444	212,077	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)		490,444		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,647,963	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,647,963	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,704,443	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)	54,170	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,014,186	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,636,087	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,636,087	30.00
31.00	Primary payer payments	1,166	31.00
32.00	Subtotal (line 30 minus line 31)	3,634,921	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)	346,512	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	225,233	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	278,694	36.00
37.00	Subtotal (see instructions)	3,860,154	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,860,154	40.00
40.01	Sequestration adjustment (see instructions)	77,203	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,930,467	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-147,516	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: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 3:17 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,334,817		3,791,716	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	08/08/2018	118,041	3.01
3.02			0	12/05/2018	20,710	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/08/2018	107,624		0	3.50
3.51		12/05/2018	32,588		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)		-140,212		138,751	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,194,605		3,930,467	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		82,241		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		147,516	6.02
7.00	Total Medicare program liability (see instructions)		1,276,846		3,782,951	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 3:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,220,168		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	08/08/2018	79,867		0	3.50
3.51		12/05/2018	52,168		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)		-132,035		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,088,133		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		47,992		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,136,125		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 3:17 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 3:17 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)	956,168	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)	214,198	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	497	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,170,366	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,170,366	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,170,366	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,055	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,159,311	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,159,311	0	19.00
19.01	Sequestration adjustment (see instructions)	23,186	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,088,133	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)	47,992	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: 14-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 3:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,434,217	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,434,217	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,448,559	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,448,559	19.00
20.00	Deductibles (exclude professional component)	168,665	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,279,894	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,279,894	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,400	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,010	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,932	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,302,904	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,302,904	30.00
30.01	Sequestration adjustment (see instructions)	26,058	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,194,605	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)	82,241	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: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 3:17 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	2,720,344	0	0	0	1.00
2.00	Temporary investments	3,227,325	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,634,880	0	0	0	4.00
5.00	Other receivable	336,501	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	323,372	0	0	0	7.00
8.00	Prepaid expenses	198,998	0	0	0	8.00
9.00	Other current assets	596,043	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)	10,037,463	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	546,486	0	0	0	12.00
13.00	Land improvements	2,311,375	0	0	0	13.00
14.00	Accumulated depreciation	-656,029	0	0	0	14.00
15.00	Buildings	8,551,579	0	0	0	15.00
16.00	Accumulated depreciation	-3,464,598	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	8,978,848	0	0	0	19.00
20.00	Accumulated depreciation	-2,428,017	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	4,135,994	0	0	0	23.00
24.00	Accumulated depreciation	-3,769,706	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	19,937	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,225,869	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	119,131	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	119,131	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,382,463	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	342,509	0	0	0	37.00
38.00	Salaries, wages, and fees payable	736,901	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	525,395	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	321,868	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,926,673	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	9,850,322	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	331,118	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,181,440	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,108,113	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,274,350				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,274,350	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,382,463	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 3:17 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,958,493		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		315,856				2.00
3.00	Total (sum of line 1 and line 2)		12,274,349		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,274,350		0		11.00
12.00	ROUNDING	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,274,350		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	ROUNDING		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	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 3:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	609,440		609,440	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	257,271		257,271	5.00
6.00	Swing bed - NF	50,729		50,729	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	917,440		917,440	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	917,440		917,440	17.00
18.00	Ancillary services	1,913,628	25,948,085	27,861,713	18.00
19.00	Outpatient services	5,575	3,206,391	3,211,966	19.00
20.00	RURAL HEALTH CLINIC	0	891,572	891,572	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	132,399	1,552,493	1,684,892	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,969,042	31,598,541	34,567,583	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,742,117		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,742,117		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 3:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,567,583	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,980,096	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,587,487	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,742,117	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-154,630	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	172,275	6.00
7.00	Income from investments	84,178	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	2,670	10.00
11.00	Rebates and refunds of expenses	22,175	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	33,873	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	665	16.00
17.00	Revenue from sale of drugs to other than patients	6,569	17.00
18.00	Revenue from sale of medical records and abstracts	6,795	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	40,659	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	102,672	24.00
25.00	Total other income (sum of lines 6-24)	472,531	25.00
26.00	Total (line 5 plus line 25)	317,901	26.00
27.00	LOSS ON ASSET DISPOSAL	2,045	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,045	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	315,856	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 3:17 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	232,403	0	232,403	73,441	305,844	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	150,561	150,561	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	177,802	177,802	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	232,403	0	232,403	401,804	634,207	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,522	6,522	0	6,522	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	56,627	56,627	0	56,627	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	63,149	63,149	0	63,149	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	232,403	63,149	295,552	401,804	697,356	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	531,025	102,970	633,995	-420,302	213,693	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	531,025	102,970	633,995	-420,302	213,693	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	763,428	166,119	929,547	-18,498	911,049	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 3:17 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	305,844		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	150,561		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	177,802		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	634,207		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,522		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	56,627		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	63,149		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	697,356		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	213,693		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	213,693		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	911,049		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 3:17 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	1.54	4,422	4,200	6,468		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.09	2,555	2,100	2,289		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.63	6,977		8,757	8,757	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)	2.63	6,977			8,757	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)					697,356	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)					697,356	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)					213,693	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					726,877	15.00
16.00	Total overhead (sum of lines 14 and 15)					940,570	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					940,570	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					940,570	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,637,926	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 3:17 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,637,926	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			51,111	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,586,815	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,757	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)			8,757	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			181.21	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)	181.21	181.21		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,198		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	398,300		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	398,300		16.00
16.01	Total program charges (see instructions)(from contractor's records)		275,372		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		307,552		16.04
16.05	Total program cost (see instructions)	0	307,552		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,860		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,302		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		307,552		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,557		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		349,109		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)		349,109		26.00
26.01	Sequestration adjustment (see instructions)		6,982		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		248,157		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)		93,970		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/29/2019 3:17 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)	634,207	634,207	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002742	0.002742	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,739	1,739	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,919	2,364	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	17,658	4,103	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	697,356	697,356	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	940,570	940,570	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.025321	0.005884	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	23,816	5,534	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	41,474	9,637	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	119	94	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	348.52	102.52	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	96	79	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	33,458	8,099	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)		51,111	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)		41,557	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 3:17 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		248,157	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)		248,157	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		93,970	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		342,127	7.00

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