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: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/19/2018 2:30 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/19/2018 Time: 2:30 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 KIRBY HOSPITAL (14-1301) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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.

[X] 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) KIMBERLY ALVIS
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	99,249	226,342	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	6,983	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		27,689		0	10.00
10.01	RURAL HEALTH CLINIC II	0		29,848		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-24,248		0	10.02
200.00	Total	0	106,232	259,631	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/19/2018 12:50 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	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	KIRBY HOSPITAL	141301	16580	1	08/08/1999	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	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	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	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	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	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2018 12:50 pm

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		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) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2018 12:50 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2018 12:50 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/19/2018 12:50 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	87,534	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2018 12:50 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	03/31/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/19/2018 12:50 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	10/30/2018	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	09/25/2018	Y	09/25/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/19/2018 12:50 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.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/19/2018 12:50 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2018 12:50 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	16	5,840	9,336.00	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)		16	5,840	9,336.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	9,336.00	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						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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2018 12:50 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)	171	18	390			1.00
2.00	HMO and other (see instructions)	137	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	533	0	1,171			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	351			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	704	18	1,912			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)	704	18	1,912	0.00	173.39	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	430	0	2,919	0.00	3.90	26.00
26.01	RURAL HEALTH CLINIC II	3,131	0	15,639	0.00	29.74	26.01
26.02	RURAL HEALTH CLINIC III	331	0	2,081	0.00	4.94	26.02
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	211.97	27.00
28.00	Observation Bed Days		0	141			28.00
29.00	Ambulance Trips	504					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2018 12:50 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	61	5	136	1.00
2.00	HMO and other (see instructions)			42	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	61	5	136	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						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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
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: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			108 SOUTH MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ATWOOD		IL	61913	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			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				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		DOUGLAS				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	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 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	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1000 MEDICAL CENTER DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MONTICELLO		IL	61856	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			07:00	18:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				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		PIATT				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	18:00	07:00	18:00	07:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				407 S. JACKSON STREET, SUITE A		1.00
		City			State	ZIP Code	
		1.00			2.00	3.00	
2.00	City, State, ZIP Code, County	CERRO GORDO			IL	61818	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			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						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		PIATT				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	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/19/2018 12:50 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)	0.380508	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,806,863	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,387,169	6.00
7.00	Medicaid cost (line 1 times line 6)	3,571,893	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)	765,030	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)	765,030	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)	120,474	1,235,356	1,355,830	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	45,841	1,235,356	1,281,197	21.00
22.00	Payments received from patients for amounts previously written off as charity care	12,169	70,624	82,793	22.00
23.00	Cost of charity care (line 21 minus line 22)	33,672	1,164,732	1,198,404	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)	2,079,539	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	247,298	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	380,458	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,699,081	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	779,674	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,978,078	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,743,108	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/19/2018 12:50 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		3,507,584	3,507,584	76,750	3,584,334	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,193,610	1,193,610	22,618	1,216,228	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	41,700	41,700	72,212	113,912	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,625,789	4,264,192	6,889,981	248,923	7,138,904	5.00
6.00	00600	MAINTENANCE & REPAIRS	239,701	266,951	506,652	0	506,652	6.00
7.00	00700	OPERATION OF PLANT	0	346,067	346,067	-48,771	297,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	50,420	50,420	8.00
9.00	00900	HOUSEKEEPING	283,924	134,506	418,430	0	418,430	9.00
10.00	01000	DIETARY	367,088	284,301	651,389	-567,830	83,559	10.00
11.00	01100	CAFETERIA	0	0	0	556,650	556,650	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,173	68,098	162,271	-14,660	147,611	14.00
15.00	01500	PHARMACY	144,704	605,671	750,375	-412,770	337,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	539,425	272,419	811,844	0	811,844	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	301,149	40,218	341,367	0	341,367	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,284,662	895,362	2,180,024	-43,999	2,136,025	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	506,272	1,857,539	2,363,811	-494,028	1,869,783	50.00
53.00	05300	ANESTHESIOLOGY	0	29,052	29,052	0	29,052	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	745,759	941,338	1,687,097	-4,939	1,682,158	54.00
56.00	03630	ULTRA SOUND	0	56,506	56,506	0	56,506	56.00
60.00	06000	LABORATORY	563,036	1,092,732	1,655,768	-2,114	1,653,654	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	559,884	205,350	765,234	-1,677	763,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,659	22,838	131,497	0	131,497	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,933	16,933	0	16,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,915	18,915	14,292	33,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	360,100	360,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	241,520	241,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	412,770	412,770	73.00
76.00	03950	SLEEP LAB	102,780	173,774	276,554	-1,183	275,371	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	9,508	9,508	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	360,795	191,098	551,893	-66,460	485,433	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,389,092	1,021,519	3,410,611	-247,949	3,162,662	88.01
88.02	08802	RURAL HEALTH CLINIC III	292,491	147,891	440,382	-67,241	373,141	88.02
91.00	09100	EMERGENCY	1,019,384	2,532,781	3,552,165	-165,646	3,386,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	315,675	202,478	518,153	64,498	582,651	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,844,442	20,431,423	33,275,865	-9,006	33,266,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	60,576	88,166	148,742	0	148,742	190.01
190.02	19002	CROSSFIT	91,041	87,220	178,261	-7,022	171,239	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,028	16,028	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,996,059	20,606,809	33,602,868	0	33,602,868	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/19/2018 12:50 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	-174,685	3,409,649		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,216,228		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	113,912		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-857,071	6,281,833		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	506,652		6.00
7.00	00700	OPERATION OF PLANT	11,746	309,042		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,420		8.00
9.00	00900	HOUSEKEEPING	0	418,430		9.00
10.00	01000	DIETARY	-19	83,540		10.00
11.00	01100	CAFETERIA	-169,801	386,849		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-36	147,575		14.00
15.00	01500	PHARMACY	0	337,605		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-62	811,782		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	341,367		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-353,861	1,782,164		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-130,227	1,739,556		50.00
53.00	05300	ANESTHESIOLOGY	-19,127	9,925		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-304,827	1,377,331		54.00
56.00	03630	ULTRA SOUND	0	56,506		56.00
60.00	06000	LABORATORY	0	1,653,654		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-35,309	728,248		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,497		67.00
68.00	06800	SPEECH PATHOLOGY	0	16,933		68.00
69.00	06900	ELECTROCARDIOLOGY	-18,609	14,598		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360,100		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	241,520		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	412,770		73.00
76.00	03950	SLEEP LAB	-116,989	158,382		76.00
76.01	03951	DIABETIC EDUCATION	0	9,508		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	485,433		88.00
88.01	08801	RURAL HEALTH CLINIC II	-364	3,162,298		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	373,141		88.02
91.00	09100	EMERGENCY	-903,452	2,483,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-58,337	524,314		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,131,030	30,135,829		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	FOUNDATION	0	148,742		190.01
190.02	19002	CROSSFIT	0	171,239		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	27,774		192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,119,284	30,483,584		200.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/19/2018 12:50 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	99,368	1.00
	0		0	99,368	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	311,503	245,147	1.00
2.00	DIABETIC EDUCATION	76.01	7,889	1,619	2.00
	0		319,392	246,766	
	D - EKG				
1.00	ELECTROCARDIOLOGY	69.00	11,357	2,935	1.00
2.00		0.00	0	0	2.00
	0		11,357	2,935	
	E - RHC ADMITTING				
1.00	ADMINISTRATIVE & GENERAL	5.00	305,960	67,757	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,816	829	2.00
3.00		0.00	0	0	3.00
	0		309,776	68,586	
	F - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	50,420	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	50,420	
	G - CROSSFIT EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,324	3,017	1.00
	0		3,324	3,017	
	H - WORKERS' COMP INS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	65,871	1.00
	0		0	65,871	
	I - TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,918	1.00
2.00		0.00	0	0	2.00
	0		0	37,918	
	J - DOCTORS BLDG COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,527	1.00
2.00	OPERATION OF PLANT	7.00	0	4,595	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,383	3.00
	0		0	18,505	
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	360,100	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	241,520	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	412,770	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	1,014,390	
	L - AMBULANCE SALARY				
1.00	AMBULANCE SERVICES	95.00	53,986	13,909	1.00
	TOTALS		53,986	13,909	
500.00	Grand Total: Increases		697,835	1,621,685	500.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/19/2018 12:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,368	12		1.00
	0		0	99,368			
	C - CAFETERIA						
1.00	DIETARY	10.00	319,392	246,766	0		1.00
2.00		0.00	0	0	0		2.00
	0		319,392	246,766			
	D - EKG						
1.00	LABORATORY	60.00	1,674	440	0		1.00
2.00	EMERGENCY	91.00	9,683	2,495	0		2.00
	0		11,357	2,935			
	E - RHC ADMITTING						
1.00	RURAL HEALTH CLINIC	88.00	50,868	12,535	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	203,521	44,197	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	55,387	11,854	0		3.00
	0		309,776	68,586			
	F - LAUNDRY						
1.00	DIETARY	10.00	0	1,672	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	19,120	0		2.00
3.00	OPERATING ROOM	50.00	0	8,227	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,939	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,677	0		5.00
6.00	SLEEP LAB	76.00	0	1,183	0		6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	231	0		7.00
8.00	EMERGENCY	91.00	0	12,147	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	543	0		9.00
10.00	CROSSFIT	190.02	0	681	0		10.00
	0		0	50,420			
	G - CROSSFIT EMPLOYEE BENEFITS						
1.00	CROSSFIT	190.02	3,324	3,017	0		1.00
	0		3,324	3,017			
	H - WORKERS' COMP INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	65,871	0		1.00
	0		0	65,871			
	I - TELEPHONE EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	3,057	0		1.00
2.00	OPERATION OF PLANT	7.00	0	34,861	0		2.00
	0		0	37,918			
	J - DOCTORS BLDG COSTS						
1.00	OPERATION OF PLANT	7.00	0	18,505	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	18,505			
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,660	0		1.00
2.00	PHARMACY	15.00	0	412,770	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	24,879	0		3.00
4.00	OPERATING ROOM	50.00	0	485,801	0		4.00
5.00	EMERGENCY	91.00	0	73,426	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	2,854	0		6.00
	TOTALS		0	1,014,390			
	L - AMBULANCE SALARY						
1.00	EMERGENCY	91.00	53,986	13,909	0		1.00
	TOTALS		53,986	13,909			
500.00	Grand Total: Decreases		697,835	1,621,685			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/19/2018 12:50 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	389,780	0	0	0	0	1.00
2.00	Land Improvements	5,936,482	270,832	0	270,832	0	2.00
3.00	Buildings and Fixtures	17,500,418	5,090,915	0	5,090,915	298,832	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	11,171,176	2,289,472	0	2,289,472	0	5.00
6.00	Movable Equipment	6,650,596	2,190,784	0	2,190,784	67,815	6.00
7.00	HIT designated Assets	3,088,157	619,008	0	619,008	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,736,609	10,461,011	0	10,461,011	366,647	8.00
9.00	Reconciling Items	-1,044,568	-7,389,001	0	-7,389,001	-7,421,741	9.00
10.00	Total (line 8 minus line 9)	45,781,177	17,850,012	0	17,850,012	7,788,388	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	389,780	0	1.00
2.00	Land Improvements	6,207,314	0	2.00
3.00	Buildings and Fixtures	22,292,501	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	13,460,648	0	5.00
6.00	Movable Equipment	8,773,565	0	6.00
7.00	HIT designated Assets	3,707,165	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,830,973	0	8.00
9.00	Reconciling Items	-1,011,828	0	9.00
10.00	Total (line 8 minus line 9)	55,842,801	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/19/2018 12:50 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	1,978,729	0	1,528,855	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,193,610	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,172,339	0	1,528,855	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	3,507,584	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,193,610	2.00
3.00	Total (sum of lines 1-2)	0	4,701,194	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/19/2018 12:50 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	42,350,243	0	42,350,243	0.772378	76,750	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,480,730	0	12,480,730	0.227622	22,618	2.00
3.00	Total (sum of lines 1-2)	54,830,973	0	54,830,973	1.000000	99,368	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	76,750	1,978,729	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,618	1,193,610	0	2.00
3.00	Total (sum of lines 1-2)	0	0	99,368	3,172,339	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,354,170	76,750	0	0	3,409,649	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,618	0	0	1,216,228	2.00
3.00	Total (sum of lines 1-2)	1,354,170	99,368	0	0	4,625,877	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/19/2018 12:50 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	-174,685	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,932	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,847,065			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-169,801	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-37	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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
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		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-36,651	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/19/2018 12:50 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	
33.01	AMBULANCE INCOME	B	-58,337	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-19,295	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-35,264	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-232,150	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-9,498	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PROPERTY TAX	A	-18,104	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-300,375	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-16,878	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,459	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	11,746	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	11,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.12	TIF EXPENSE NOT RELATED TO THE HOSPI	A	-66,133	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.14	NON-ALLOWABLE DONATION EXPENSE	A	-162,357	ADMINISTRATIVE & GENERAL	5.00	0	33.14
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
34.01	MISC EXPENSE - A&G	A	-157	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	MISC EXPENSE - DIETARY	A	-19	DIETARY	10.00	0	34.02
34.03	MISC EXPENSE - CENTRAL SERVICES	A	-36	CENTRAL SERVICES & SUPPLY	14.00	0	34.03
34.04	MISC EXPENSE - HIM	A	-25	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISC EXPENSE - ANESETHSIA	A	-27	ANESTHESIOLOGY	53.00	0	34.05
34.06	MISC EXPENSE - PT	A	-45	PHYSICAL THERAPY	66.00	0	34.06
34.09	MISC EXPENSE - RHC II	A	-364	RURAL HEALTH CLINIC II	88.01	0	34.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,119,284				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/19/2018 12:50 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	353,861	353,861	0	0	0	1.00
2.00	50.00	OPERATING ROOM	130,227	130,227	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	19,100	19,100	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	304,827	304,827	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	18,609	18,609	0	0	0	5.00
6.00	76.00	SLEEP LAB	116,989	116,989	0	0	0	6.00
7.00	91.00	EMERGENCY	2,072,332	903,452	1,168,880	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			3,015,945	1,847,065	1,168,880		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	353,861		1.00
2.00	50.00	OPERATING ROOM	0	0	0	130,227		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	19,100		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	304,827		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	18,609		5.00
6.00	76.00	SLEEP LAB	0	0	0	116,989		6.00
7.00	91.00	EMERGENCY	0	0	0	903,452		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	1,847,065		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/19/2018 12:50 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					86	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	260.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.81	36.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					19,175	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)					19,175	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)					19,175	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)					73.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,416	22.00
23.00	Total salary equivalency (see instructions)					57,416	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)					3,166	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)					3,166	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)					464	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,630	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)					3,630	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/19/2018 12:50 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)	73.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	57,416	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,630	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)	61,046	63.00
64.00	Total cost of outside supplier services (from your records)	16,933	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	3,166	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	464	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,630	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	464	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	464	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,409,649	3,409,649				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,216,228		1,216,228			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,912	0	0	113,912		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,281,833	209,520	316,635	25,707	6,833,695	5.00
6.00	00600	MAINTENANCE & REPAIRS	506,652	11,167	16,999	2,101	536,919	6.00
7.00	00700	OPERATION OF PLANT	309,042	620,123	50,931	0	980,096	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,420	13,069	0	0	63,489	8.00
9.00	00900	HOUSEKEEPING	418,430	49,175	3,732	2,489	473,826	9.00
10.00	01000	DIETARY	83,540	107,821	31,712	418	223,491	10.00
11.00	01100	CAFETERIA	386,849	48,637	0	2,731	438,217	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	147,575	56,619	1,900	826	206,920	14.00
15.00	01500	PHARMACY	337,605	33,790	8,146	1,269	380,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	811,782	65,056	7,935	4,729	889,502	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	341,367	0	0	2,640	344,007	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,782,164	400,264	72,893	11,263	2,266,584	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,739,556	306,423	137,774	4,438	2,188,191	50.00
53.00	05300	ANESTHESIOLOGY	9,925	0	0	0	9,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,377,331	154,266	293,194	6,538	1,831,329	54.00
56.00	03630	ULTRA SOUND	56,506	5,211	55,114	0	116,831	56.00
60.00	06000	LABORATORY	1,653,654	57,281	59,861	4,921	1,775,717	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	728,248	185,905	14,596	4,909	933,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,497	0	0	953	132,450	67.00
68.00	06800	SPEECH PATHOLOGY	16,933	0	0	0	16,933	68.00
69.00	06900	ELECTROCARDIOLOGY	14,598	0	0	100	14,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,100	0	0	0	360,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,520	0	0	0	241,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	412,770	0	0	0	412,770	73.00
76.00	03950	SLEEP LAB	158,382	27,090	9,339	901	195,712	76.00
76.01	03951	DIABETIC EDUCATION	9,508	0	0	69	9,577	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	485,433	25,601	3,721	2,717	517,472	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,162,298	322,594	12,635	19,161	3,516,688	88.01
88.02	08802	RURAL HEALTH CLINIC III	373,141	188,552	17,930	2,079	581,702	88.02
91.00	09100	EMERGENCY	2,483,067	260,350	10,218	8,379	2,762,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	524,314	35,816	86,629	3,241	650,000	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,135,829	3,184,330	1,211,894	112,579	29,904,843	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,028	0	0	13,028	190.00
190.01	19001	FOUNDATION	148,742	4,136	0	531	153,409	190.01
190.02	19002	CROSSFIT	171,239	143,926	4,334	769	320,268	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,774	0	0	33	27,807	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	64,229	0	0	64,229	194.00
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)	30,483,584	3,409,649	1,216,228	113,912	30,483,584	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	6,833,695					5.00
6.00	00600	MAINTENANCE & REPAIRS	155,144	692,063				6.00
7.00	00700	OPERATION OF PLANT	283,202	146,164	1,409,462			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,345	3,080	8,582	93,496		8.00
9.00	00900	HOUSEKEEPING	136,913	11,591	32,289	0	654,619	9.00
10.00	01000	DIETARY	64,578	25,414	70,798	3,100	29,054	10.00
11.00	01100	CAFETERIA	126,624	11,464	31,936	0	13,106	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,790	13,345	37,178	0	15,257	14.00
15.00	01500	PHARMACY	110,036	7,964	22,187	0	9,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,024	15,334	42,718	0	17,530	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	99,402	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	654,936	94,343	262,820	35,455	107,858	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	632,284	72,224	201,204	15,260	82,570	50.00
53.00	05300	ANESTHESIOLOGY	2,868	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,168	36,361	101,295	9,159	41,569	54.00
56.00	03630	ULTRA SOUND	33,759	1,228	3,422	0	1,404	56.00
60.00	06000	LABORATORY	513,099	13,501	37,612	0	15,435	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	269,783	43,818	122,070	3,107	50,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,272	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,893	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,247	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,052	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,788	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,271	0	0	0	0	73.00
76.00	03950	SLEEP LAB	56,552	6,385	17,788	2,194	7,300	76.00
76.01	03951	DIABETIC EDUCATION	2,767	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	149,525	6,034	0	0	6,898	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,016,149	76,036	211,823	429	86,927	88.01
88.02	08802	RURAL HEALTH CLINIC III	168,085	0	0	0	50,808	88.02
91.00	09100	EMERGENCY	798,092	61,365	170,952	22,518	70,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	187,819	8,442	23,518	1,008	9,651	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,666,467	654,093	1,398,192	92,230	614,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,764	3,071	8,554	0	0	190.00
190.01	19001	FOUNDATION	44,328	975	2,716	0	1,114	190.01
190.02	19002	CROSSFIT	92,542	33,924	0	1,266	38,783	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,035	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	18,559	0	0	0	0	194.00
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)	6,833,695	692,063	1,409,462	93,496	654,619	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	416,435					10.00
11.00	01100	CAFETERIA	0	621,347				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,844	346,334			14.00
15.00	01500	PHARMACY	0	8,769	731	539,602		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,100	1,565	0	1,280,773	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	416,435	108,632	7,504	0	256,795	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,305	20,380	0	120,521	50.00
53.00	05300	ANESTHESIOLOGY	0	4,828	1,358	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,986	6,806	0	49,822	54.00
56.00	03630	ULTRA SOUND	0	0	1,983	0	6,276	56.00
60.00	06000	LABORATORY	0	57,839	94,661	0	196,727	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	38,329	2,318	0	80,176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,242	96	0	2,049	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	512	68.00
69.00	06900	ELECTROCARDIOLOGY	0	690	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	79,126	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	53,070	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	539,602	0	73.00
76.00	03950	SLEEP LAB	0	7,144	3,199	0	11,527	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	11,028	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	100,454	44,675	0	13,320	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	8,868	0	0	88.02
91.00	09100	EMERGENCY	0	88,335	5,856	0	503,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,278	1,232	0	39,960	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	416,435	612,775	344,456	539,602	1,280,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	2,562	0	0	0	190.01
190.02	19002	CROSSFIT	0	6,010	1,878	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
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)	416,435	621,347	346,334	539,602	1,280,773	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	443,409					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,211,362	-111,993	4,099,369		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,375,939	0	3,375,939		50.00
53.00	05300	ANESTHESIOLOGY	443,409	462,388	0	462,388		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,663,495	0	2,663,495		54.00
56.00	03630	ULTRA SOUND	0	164,903	0	164,903		56.00
60.00	06000	LABORATORY	0	2,704,591	0	2,704,591		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	111,993	111,993		64.00
66.00	06600	PHYSICAL THERAPY	0	1,543,354	0	1,543,354		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	180,109	0	180,109		67.00
68.00	06800	SPEECH PATHOLOGY	0	22,338	0	22,338		68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,635	0	19,635		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	543,278	0	543,278		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	364,378	0	364,378		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,071,643	0	1,071,643		73.00
76.00	03950	SLEEP LAB	0	307,801	0	307,801		76.00
76.01	03951	DIABETIC EDUCATION	0	12,344	0	12,344		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	690,957	0	690,957		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,066,501	0	5,066,501		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	809,463	0	809,463		88.02
91.00	09100	EMERGENCY	0	4,482,375	0	4,482,375		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	939,908	0	939,908		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,409	29,636,762	0	29,636,762		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,417	0	28,417		190.00
190.01	19001	FOUNDATION	0	205,104	0	205,104		190.01
190.02	19002	CROSSFIT	0	494,671	0	494,671		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,842	0	35,842		192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	82,788	0	82,788		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	443,409	30,483,584	0	30,483,584		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/19/2018 12:50 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,660	209,520	316,635	543,815	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	11,167	16,999	28,166	0	6.00
7.00	00700	OPERATION OF PLANT	11,746	620,123	50,931	682,800	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,069	0	13,069	0	8.00
9.00	00900	HOUSEKEEPING	0	49,175	3,732	52,907	0	9.00
10.00	01000	DIETARY	0	107,821	31,712	139,533	0	10.00
11.00	01100	CAFETERIA	0	48,637	0	48,637	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,619	1,900	58,519	0	14.00
15.00	01500	PHARMACY	15,205	33,790	8,146	57,141	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,056	7,935	72,991	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,591	400,264	72,893	481,748	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	145,563	306,423	137,774	589,760	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,337	154,266	293,194	566,797	0	54.00
56.00	03630	ULTRA SOUND	0	5,211	55,114	60,325	0	56.00
60.00	06000	LABORATORY	0	57,281	59,861	117,142	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	185,905	14,596	200,501	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	396	27,090	9,339	36,825	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,601	3,721	29,322	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	322,594	12,635	335,229	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	188,552	17,930	206,482	0	88.02
91.00	09100	EMERGENCY	576	260,350	10,218	271,144	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	35,816	86,629	122,445	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	319,074	3,184,330	1,211,894	4,715,298	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,028	0	13,028	0	190.00
190.01	19001	FOUNDATION	0	4,136	0	4,136	0	190.01
190.02	19002	CROSSFIT	0	143,926	4,334	148,260	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	0	0	11,746	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	64,229	0	64,229	0	194.00
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)	330,820	3,409,649	1,216,228	4,956,697	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	543,815					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,346	40,512				6.00
7.00	00700	OPERATION OF PLANT	22,536	8,557	713,893			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,460	180	4,347	19,056		8.00
9.00	00900	HOUSEKEEPING	10,895	678	16,355	0	80,835	9.00
10.00	01000	DIETARY	5,139	1,488	35,859	632	3,588	10.00
11.00	01100	CAFETERIA	10,076	671	16,176	0	1,618	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,758	781	18,830	0	1,884	14.00
15.00	01500	PHARMACY	8,756	466	11,238	0	1,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,453	898	21,636	0	2,165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,910	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,118	5,523	133,120	7,226	13,319	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,315	4,228	101,910	3,110	10,196	50.00
53.00	05300	ANESTHESIOLOGY	228	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,110	2,128	51,306	1,867	5,133	54.00
56.00	03630	ULTRA SOUND	2,686	72	1,733	0	173	56.00
60.00	06000	LABORATORY	40,831	790	19,051	0	1,906	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	21,469	2,565	61,828	633	6,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,046	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	389	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	338	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,280	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,554	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,491	0	0	0	0	73.00
76.00	03950	SLEEP LAB	4,500	374	9,009	447	901	76.00
76.01	03951	DIABETIC EDUCATION	220	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,899	353	0	0	852	88.00
88.01	08801	RURAL HEALTH CLINIC II	80,873	4,451	107,288	88	10,734	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,376	0	0	0	6,274	88.02
91.00	09100	EMERGENCY	63,510	3,592	86,587	4,590	8,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,946	494	11,912	205	1,192	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	530,508	38,289	708,185	18,798	75,908	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	300	180	4,333	0	0	190.00
190.01	19001	FOUNDATION	3,527	57	1,375	0	138	190.01
190.02	19002	CROSSFIT	7,364	1,986	0	258	4,789	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	639	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	1,477	0	0	0	0	194.00
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)	543,815	40,512	713,893	19,056	80,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	186,239					10.00
11.00	01100	CAFETERIA	0	77,178				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,720	86,492			14.00
15.00	01500	PHARMACY	0	1,089	183	79,997		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,092	391	0	125,626	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	186,239	13,493	1,874	0	25,188	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,379	5,090	0	11,821	50.00
53.00	05300	ANESTHESIOLOGY	0	600	339	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,203	1,700	0	4,887	54.00
56.00	03630	ULTRA SOUND	0	0	495	0	616	56.00
60.00	06000	LABORATORY	0	7,184	23,637	0	19,296	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,761	579	0	7,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	900	24	0	201	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	50	68.00
69.00	06900	ELECTROCARDIOLOGY	0	86	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,761	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,254	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	79,997	0	73.00
76.00	03950	SLEEP LAB	0	887	799	0	1,131	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,754	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,477	11,157	0	1,307	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,215	0	0	88.02
91.00	09100	EMERGENCY	0	10,972	1,463	0	49,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,270	308	0	3,920	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	186,239	76,113	86,023	79,997	125,626	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	318	0	0	0	190.01
190.02	19002	CROSSFIT	0	747	469	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
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)	186,239	77,178	86,492	79,997	125,626	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,910					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		919,848	0	919,848		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		781,809	0	781,809		50.00
53.00	05300	ANESTHESIOLOGY		1,167	0	1,167		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		683,131	0	683,131		54.00
56.00	03630	ULTRA SOUND		66,100	0	66,100		56.00
60.00	06000	LABORATORY		229,837	0	229,837		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
66.00	06600	PHYSICAL THERAPY		306,386	0	306,386		66.00
67.00	06700	OCCUPATIONAL THERAPY		4,171	0	4,171		67.00
68.00	06800	SPEECH PATHOLOGY		439	0	439		68.00
69.00	06900	ELECTROCARDIOLOGY		424	0	424		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		28,041	0	28,041		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		18,808	0	18,808		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		89,488	0	89,488		73.00
76.00	03950	SLEEP LAB		54,873	0	54,873		76.00
76.01	03951	DIABETIC EDUCATION		220	0	220		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		45,180	0	45,180		88.00
88.01	08801	RURAL HEALTH CLINIC II		563,604	0	563,604		88.01
88.02	08802	RURAL HEALTH CLINIC III		228,347	0	228,347		88.02
91.00	09100	EMERGENCY		499,866	0	499,866		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		157,692	0	157,692		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,679,431	0	4,679,431		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		17,841	0	17,841		190.00
190.01	19001	FOUNDATION		9,551	0	9,551		190.01
190.02	19002	CROSSFIT		163,873	0	163,873		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES		12,385	0	12,385		192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE		65,706	0	65,706		194.00
200.00		Cross Foot Adjustments	7,910	7,910	0	7,910		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	7,910	4,956,697	0	4,956,697		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,442					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,193,610				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,992,734			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,066	310,745	2,931,749	-6,833,695	23,649,889	5.00
6.00	00600	MAINTENANCE & REPAIRS	270	16,683	239,701	0	536,919	6.00
7.00	00700	OPERATION OF PLANT	14,994	49,984	0	0	980,096	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	0	0	0	63,489	8.00
9.00	00900	HOUSEKEEPING	1,189	3,663	283,924	0	473,826	9.00
10.00	01000	DIETARY	2,607	31,122	47,696	0	223,491	10.00
11.00	01100	CAFETERIA	1,176	0	311,503	0	438,217	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,369	1,865	94,173	0	206,920	14.00
15.00	01500	PHARMACY	817	7,995	144,704	0	380,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,573	7,787	539,425	0	889,502	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	301,149	0	344,007	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,678	71,537	1,284,662	0	2,266,584	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,409	135,212	506,272	0	2,188,191	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730	287,742	745,759	0	1,831,329	54.00
56.00	03630	ULTRA SOUND	126	54,089	0	0	116,831	56.00
60.00	06000	LABORATORY	1,385	58,748	561,362	0	1,775,717	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,495	14,325	559,884	0	933,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	108,659	0	132,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	16,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	11,356	0	14,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	360,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	241,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	412,770	73.00
76.00	03950	SLEEP LAB	655	9,165	102,780	0	195,712	76.00
76.01	03951	DIABETIC EDUCATION	0	0	7,889	0	9,577	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	3,652	309,927	0	517,472	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,800	12,400	2,185,571	0	3,516,688	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,559	17,597	237,104	0	581,702	88.02
91.00	09100	EMERGENCY	6,295	10,028	955,715	0	2,762,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	85,018	369,661	0	650,000	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,994	1,189,357	12,840,625	-6,833,695	23,071,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	0	0	0	13,028	190.00
190.01	19001	FOUNDATION	100	0	60,576	0	153,409	190.01
190.02	19002	CROSSFIT	3,480	4,253	87,717	0	320,268	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,816	0	27,807	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	1,553	0	0	0	64,229	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,409,649	1,216,228	113,912		6,833,695	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.358155	1.018949	0.008767		0.288953	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		543,815	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.022994	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	70,994					6.00
7.00	00700	OPERATION OF PLANT	14,994	51,901				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	316	81,638			8.00
9.00	00900	HOUSEKEEPING	1,189	1,189	0	58,739		9.00
10.00	01000	DIETARY	2,607	2,607	2,707	2,607	8,707	10.00
11.00	01100	CAFETERIA	1,176	1,176	0	1,176	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,369	1,369	0	1,369	0	14.00
15.00	01500	PHARMACY	817	817	0	817	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,573	1,573	0	1,573	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,678	9,678	30,958	9,678	8,707	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,409	7,409	13,325	7,409	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730	3,730	7,997	3,730	0	54.00
56.00	03630	ULTRA SOUND	126	126	0	126	0	56.00
60.00	06000	LABORATORY	1,385	1,385	0	1,385	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,495	4,495	2,713	4,495	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	655	655	1,916	655	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	0	0	619	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,800	7,800	375	7,800	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	4,559	0	88.02
91.00	09100	EMERGENCY	6,295	6,295	19,662	6,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	866	880	866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,099	51,486	80,533	55,159	8,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315	0	0	0	190.00
190.01	19001	FOUNDATION	100	100	0	100	0	190.01
190.02	19002	CROSSFIT	3,480	0	1,105	3,480	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
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)	692,063	1,409,462	93,496	654,619	416,435	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.748190	27.156741	1.145251	11.144538	47.827610	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,512	713,893	19,056	80,835	186,239	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.570640	13.754899	0.233421	1.376173	21.389572	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/19/2018 12:50 pm

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	14.00	15.00	16.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,612					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	281	1,576,149				14.00
15.00	01500	PHARMACY	178	3,328	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,159	7,122	0	10,000		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,205	34,151	0	2,005	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	879	92,749	0	941	0	50.00
53.00	05300	ANESTHESIOLOGY	98	6,179	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,177	30,976	0	389	0	54.00
56.00	03630	ULTRA SOUND	0	9,025	0	49	0	56.00
60.00	06000	LABORATORY	1,174	430,795	0	1,536	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	778	10,547	0	626	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	147	435	0	16	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360,100	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	241,520	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
76.00	03950	SLEEP LAB	145	14,559	0	90	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	50,186	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,039	203,314	0	104	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	40,358	0	0	0	88.02
91.00	09100	EMERGENCY	1,793	26,651	0	3,928	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	371	5,607	0	312	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,438	1,567,602	100	10,000	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	52	0	0	0	0	190.01
190.02	19002	CROSSFIT	122	8,547	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
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)	621,347	346,334	539,602	1,280,773	443,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.266334	0.219734	5,396.020000	128.077300	4,434.090000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,178	86,492	79,997	125,626	7,910	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.119410	0.054876	799.970000	12.562600	79.100000	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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-2 | Date/Time Prepared: 11/19/2018 12:50 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-111,993	7.00
8.00		IV THERAPY	1	64.00	111,993	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/19/2018 12:50 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	4,099,369		4,099,369	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,375,939		3,375,939	0	0	50.00
53.00	05300	ANESTHESIOLOGY	462,388		462,388	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,663,495		2,663,495	0	0	54.00
56.00	03630	ULTRA SOUND	164,903		164,903	0	0	56.00
60.00	06000	LABORATORY	2,704,591		2,704,591	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	111,993		111,993	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,543,354	0	1,543,354	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,109	0	180,109	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,338	0	22,338	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,635		19,635	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	543,278		543,278	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	364,378		364,378	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,071,643		1,071,643	0	0	73.00
76.00	03950	SLEEP LAB	307,801		307,801	0	0	76.00
76.01	03951	DIABETIC EDUCATION	12,344		12,344	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	690,957		690,957	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,066,501		5,066,501	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	809,463		809,463	0	0	88.02
91.00	09100	EMERGENCY	4,482,375		4,482,375	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	335,088		335,088		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	939,908		939,908	0	0	95.00
200.00		Subtotal (see instructions)	29,971,850	0	29,971,850	0	0	200.00
201.00		Less Observation Beds	335,088		335,088		0	201.00
202.00		Total (see instructions)	29,636,762	0	29,636,762	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/19/2018 12:50 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	6,943,742		6,943,742			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	658,592	10,989,042	11,647,634	0.289839	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	112,144	2,943,160	3,055,304	0.151339	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,044	10,487,521	10,670,565	0.249611	0.000000	54.00
56.00	03630	ULTRA SOUND	156,763	1,067,972	1,224,735	0.134644	0.000000	56.00
60.00	06000	LABORATORY	679,094	13,750,746	14,429,840	0.187430	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	19,988	348,216	368,204	0.304160	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	355,408	3,631,561	3,986,969	0.387100	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,669	180,089	504,758	0.356822	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	23,218	62,356	85,574	0.261037	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	69,164	645,988	715,152	0.027456	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	334,921	860,623	1,195,544	0.454419	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,298	377,632	491,930	0.740711	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,264,768	3,000,924	4,265,692	0.251224	0.000000	73.00
76.00	03950	SLEEP LAB	0	1,028,918	1,028,918	0.299150	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	44,531	44,531	0.277200	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	680,224	680,224			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,556,515	3,556,515			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	478,138	478,138			88.02
91.00	09100	EMERGENCY	3,758	10,081,748	10,085,506	0.444437	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	282,378	282,378	1.186665	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,145,560	2,145,560	0.438071	0.000000	95.00
200.00		Subtotal (see instructions)	11,243,571	66,643,842	77,887,413			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,243,571	66,643,842	77,887,413			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/19/2018 12:50 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	03630	ULTRA SOUND	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
76.01	03951	DIABETIC EDUCATION	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/19/2018 12:50 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	781,809	11,647,634	0.067122	155,613	10,445	50.00
53.00	05300	ANESTHESIOLOGY	1,167	3,055,304	0.000382	6,233	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,131	10,670,565	0.064020	41,718	2,671	54.00
56.00	03630	ULTRA SOUND	66,100	1,224,735	0.053971	37,143	2,005	56.00
60.00	06000	LABORATORY	229,837	14,429,840	0.015928	127,245	2,027	60.00
64.00	06400	INTRAVENOUS THERAPY	0	368,204	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	306,386	3,986,969	0.076847	20,329	1,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,171	504,758	0.008263	13,882	115	67.00
68.00	06800	SPEECH PATHOLOGY	439	85,574	0.005130	3,211	16	68.00
69.00	06900	ELECTROCARDIOLOGY	424	715,152	0.000593	30,205	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,041	1,195,544	0.023455	62,441	1,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,808	491,930	0.038233	22,812	872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,488	4,265,692	0.020979	185,350	3,888	73.00
76.00	03950	SLEEP LAB	54,873	1,028,918	0.053331	0	0	76.00
76.01	03951	DIABETIC EDUCATION	220	44,531	0.004940	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,180	680,224	0.066419	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	563,604	3,556,515	0.158471	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	228,347	478,138	0.477576	0	0	88.02
91.00	09100	EMERGENCY	499,866	10,085,506	0.049563	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,190	282,378	0.266274	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,677,081	68,798,111		706,182	25,086	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	443,409	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	443,409	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 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	11,647,634	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	443,409	0	3,055,304	0.145128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,670,565	0.000000	54.00
56.00	03630	ULTRA SOUND	0	0	0	1,224,735	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	14,429,840	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	368,204	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,986,969	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	504,758	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85,574	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	715,152	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,195,544	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	491,930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,265,692	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	1,028,918	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	44,531	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	680,224	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,556,515	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	478,138	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	10,085,506	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	282,378	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	443,409	0	68,798,111		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/19/2018 12:50 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	155,613	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,233	905	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	41,718	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.000000	37,143	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	127,245	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	20,329	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,882	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,211	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	30,205	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	62,441	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,812	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	185,350	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		706,182	905	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289839	0	2,669,395	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.151339	0	714,167	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.249611	0	2,538,562	0	0	54.00
56.00	03630	ULTRA SOUND	0.134644	0	282,525	0	0	56.00
60.00	06000	LABORATORY	0.187430	0	3,576,360	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.304160	0	166,563	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.387100	0	1,052,381	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356822	0	31,572	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.261037	0	26,220	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027456	0	213,833	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.454419	0	251,384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.740711	0	88,131	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251224	0	1,666,688	36,539	0	73.00
76.00	03950	SLEEP LAB	0.299150	0	254,974	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.277200	0	1,748	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.444437	0	2,396,897	22,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.186665	0	120,518	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.438071		0			95.00
200.00		Subtotal (see instructions)		0	16,051,918	59,057	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	16,051,918	59,057	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/19/2018 12:50 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	773,695	0		50.00
53.00	05300	ANESTHESIOLOGY	108,081	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	633,653	0		54.00
56.00	03630	ULTRA SOUND	38,040	0		56.00
60.00	06000	LABORATORY	670,317	0		60.00
64.00	06400	INTRAVENOUS THERAPY	50,662	0		64.00
66.00	06600	PHYSICAL THERAPY	407,377	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,266	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,844	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,871	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,234	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,280	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	418,712	9,179		73.00
76.00	03950	SLEEP LAB	76,275	0		76.00
76.01	03951	DIABETIC EDUCATION	485	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
91.00	09100	EMERGENCY	1,065,270	10,008		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	143,014	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,589,076	19,187		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,589,076	19,187		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289839	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.151339	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.249611	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.134644	0	0	0	0	56.00
60.00	06000	LABORATORY	0.187430	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.304160	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.387100	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356822	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.261037	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027456	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.454419	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.740711	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251224	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.299150	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.277200	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.444437	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.186665	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.438071		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/19/2018 12:50 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	03630	ULTRA SOUND	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	531	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)	390	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	582	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)	589	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	145	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)	206	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	171	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)	266	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)	267	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,099,369	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)	22,534	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)	32,014	25.00
26.00	Total swing-bed cost (see instructions)	2,837,441	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,261,928	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)	1,261,928	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,376.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	406,383	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)	406,383	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/19/2018 12:50 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						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)	191,634	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	598,017	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)	632,152	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	634,528	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,266,680	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)	141	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,376.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	335,088	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/19/2018 12:50 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	919,848	4,099,369	0.224388	335,088	75,190	90.00
91.00	Nursing School cost	0	4,099,369	0.000000	335,088	0	91.00
92.00	Allied health cost	0	4,099,369	0.000000	335,088	0	92.00
93.00	All other Medical Education	0	4,099,369	0.000000	335,088	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/19/2018 12:50 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		720,917		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289839	155,613	45,103	50.00
53.00	05300	ANESTHESIOLOGY	0.151339	6,233	943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.249611	41,718	10,413	54.00
56.00	03630	ULTRA SOUND	0.134644	37,143	5,001	56.00
60.00	06000	LABORATORY	0.187430	127,245	23,850	60.00
64.00	06400	INTRAVENOUS THERAPY	0.304160	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.387100	20,329	7,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356822	13,882	4,953	67.00
68.00	06800	SPEECH PATHOLOGY	0.261037	3,211	838	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027456	30,205	829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.454419	62,441	28,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.740711	22,812	16,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251224	185,350	46,564	73.00
76.00	03950	SLEEP LAB	0.299150	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.277200	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.444437	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.186665	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		706,182	191,634	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)		706,182		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289839	2,954	856	50.00
53.00	05300	ANESTHESIOLOGY	0.151339	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.249611	28,911	7,217	54.00
56.00	03630	ULTRA SOUND	0.134644	6,539	880	56.00
60.00	06000	LABORATORY	0.187430	186,711	34,995	60.00
64.00	06400	INTRAVENOUS THERAPY	0.304160	460	140	64.00
66.00	06600	PHYSICAL THERAPY	0.387100	132,415	51,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356822	114,733	40,939	67.00
68.00	06800	SPEECH PATHOLOGY	0.261037	4,610	1,203	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027456	2,069	57	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.454419	63,883	29,030	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.740711	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.251224	318,005	79,890	73.00
76.00	03950	SLEEP LAB	0.299150	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.277200	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.444437	3,757	1,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.186665	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		865,047	248,135	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)		865,047		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/19/2018 12:50 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,608,263	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,608,263	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,654,346	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 (for CAH, see instructions)	19,842	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,481,133	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,153,371	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,153,371	30.00
31.00	Primary payer payments	311	31.00
32.00	Subtotal (line 30 minus line 31)	2,153,060	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)	362,894	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	235,881	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	198,093	36.00
37.00	Subtotal (see instructions)	2,388,941	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,388,941	40.00
40.01	Sequestration adjustment (see instructions)	47,779	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,114,820	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	226,342	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/19/2018 12:50 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		433,968		2,702,320	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	02/27/2018	587,500	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		-587,500	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)		433,968		2,114,820	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		99,249		226,342	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		533,217		2,341,162	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: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/19/2018 12:50 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		1,487,986		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,487,986		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		6,983		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,494,969		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: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/19/2018 12:50 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: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,279,347	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)	250,616	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	533	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)	1,529,963	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,529,963	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)	1,529,963	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,484	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)	1,525,479	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)	1,525,479	0	19.00
19.01	Sequestration adjustment (see instructions)	30,510	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,487,986	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)	6,983	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: 14-1301	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/19/2018 12:50 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	598,017	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)	598,017	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	603,997	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)	603,997	19.00
20.00	Deductibles (exclude professional component)	64,467	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	539,530	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	539,530	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,029	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	4,569	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,810	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	544,099	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)	544,099	30.00
30.01	Sequestration adjustment (see instructions)	10,882	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	433,968	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)	99,249	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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/19/2018 12:50 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	8,918,867	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,147,437	0	0	0	4.00
5.00	Other receivable	230,348	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	317,251	0	0	0	7.00
8.00	Prepaid expenses	889,115	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,503,018	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	389,780	0	0	0	12.00
13.00	Land improvements	6,657,483	0	0	0	13.00
14.00	Accumulated depreciation	-2,088,708	0	0	0	14.00
15.00	Buildings	21,842,332	0	0	0	15.00
16.00	Accumulated depreciation	-6,236,244	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	13,460,648	0	0	0	19.00
20.00	Accumulated depreciation	-4,423,501	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,773,565	0	0	0	23.00
24.00	Accumulated depreciation	-4,431,915	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	3,707,165	0	0	0	27.00
28.00	Accumulated depreciation	-3,084,833	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,011,828	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,577,600	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	41,916,896	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	397,248	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42,314,144	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	93,394,762	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,237,806	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,226,651	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	787,812	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	0	0	0	0	43.00
44.00	Other current liabilities	204,522	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,456,791	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	26,991,416	0	0	0	46.00
47.00	Notes payable	107,270	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,098,686	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,555,477	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	60,839,285				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)	60,839,285	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	93,394,762	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/19/2018 12:50 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		54,808,820		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,612,828				2.00
3.00	Total (sum of line 1 and line 2)		60,421,648		0		3.00
4.00	CHANGE IN RESTRICTED NET ASSETS	425,576		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)		425,576		0		10.00
11.00	Subtotal (line 3 plus line 10)		60,847,224		0		11.00
12.00	AUXILIARY NET LOSS	7,939		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)		7,939		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60,839,285		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	CHANGE IN RESTRICTED NET ASSETS		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	AUXILIARY NET LOSS		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: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/19/2018 12:50 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,819,585		1,819,585	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	4,023,686		4,023,686	5.00
6.00	Swing bed - NF	1,205,046		1,205,046	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)	7,048,317		7,048,317	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,048,317		7,048,317	17.00
18.00	Ancillary services	4,200,856	49,177,136	53,377,992	18.00
19.00	Outpatient services	3,758	10,545,493	10,549,251	19.00
20.00	RURAL HEALTH CLINIC	0	680,224	680,224	20.00
20.01	RURAL HEALTH CLINIC II	0	3,556,515	3,556,515	20.01
20.02	RURAL HEALTH CLINIC III	0	478,138	478,138	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,196,617	2,196,617	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	327,904	5,740,600	6,068,504	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,580,835	72,374,723	83,955,558	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,602,868		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	GAIN ON SALE OF ASSETS	85,305			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)		85,305		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,517,563		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/19/2018 12:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	83,955,558	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,399,350	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,556,208	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,517,563	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,038,645	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	228,398	6.00
7.00	Income from investments	401,483	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	169,801	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	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	0	22.00
23.00	Governmental appropriations	30,439	23.00
24.00	TRUST HOSPITAL INCOME	1,023,432	24.00
24.01	EHR INCENTIVE REIMBURSEMENT	47,028	24.01
24.02	OTHER DOCTOR BUIDLING INCOME	24,870	24.02
24.03	340B NET REVENUES	319,972	24.03
24.04	PHYSICAL THERAPY	35,264	24.04
24.05	AMBULANCE	58,337	24.05
24.06	CROSSFIT INCOME	125,431	24.06
24.07	TIF INCOME	33,139	24.07
24.08	MISCELLANEOUS INCOME	76,589	24.08
25.00	Total other income (sum of lines 6-24)	2,574,183	25.00
26.00	Total (line 5 plus line 25)	5,612,828	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,612,828	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 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	71,139	0	71,139	0	71,139	1.00
2.00	Physician Assistant	113,575	0	113,575	0	113,575	2.00
3.00	Nurse Practitioner	1,216	0	1,216	0	1,216	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	123,997	0	123,997	0	123,997	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	6,700	6,700	0	6,700	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)	309,927	6,700	316,627	0	316,627	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	44,155	44,155	0	44,155	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44,155	44,155	0	44,155	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	309,927	50,855	360,782	0	360,782	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	11,729	11,729	-3,057	8,672	29.00
30.00	Administrative Costs	50,868	128,514	179,382	-63,403	115,979	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	50,868	140,243	191,111	-66,460	124,651	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	360,795	191,098	551,893	-66,460	485,433	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 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	71,139		1.00
2.00	Physician Assistant	0	113,575		2.00
3.00	Nurse Practitioner	0	1,216		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	123,997		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	6,700		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	316,627		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	44,155		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44,155		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	360,782		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	8,672		29.00
30.00	Administrative Costs	0	115,979		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,651		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	485,433		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC II | 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	1,035,763	0	1,035,763	0	1,035,763	1.00
2.00	Physician Assistant	299,058	0	299,058	0	299,058	2.00
3.00	Nurse Practitioner	103,324	0	103,324	0	103,324	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	556,799	0	556,799	0	556,799	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	14,620	14,620	0	14,620	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)	1,994,944	14,620	2,009,564	0	2,009,564	10.00
11.00	Physician Services Under Agreement	0	66,468	66,468	0	66,468	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	66,468	66,468	0	66,468	14.00
15.00	Medical Supplies	0	173,278	173,278	0	173,278	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	173,278	173,278	0	173,278	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,994,944	254,366	2,249,310	0	2,249,310	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	1,189	0	1,189	0	1,189	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)	1,189	0	1,189	0	1,189	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,848	2,848	0	2,848	29.00
30.00	Administrative Costs	392,959	764,305	1,157,264	-247,949	909,315	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	392,959	767,153	1,160,112	-247,949	912,163	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,389,092	1,021,519	3,410,611	-247,949	3,162,662	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,035,763		1.00
2.00	Physician Assistant	0	299,058		2.00
3.00	Nurse Practitioner	0	103,324		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	556,799		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	14,620		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	2,009,564		10.00
11.00	Physician Services Under Agreement	0	66,468		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	66,468		14.00
15.00	Medical Supplies	0	173,278		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	173,278		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,249,310		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	1,189		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	1,189		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-364	2,484		29.00
30.00	Administrative Costs	0	909,315		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-364	911,799		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-364	3,162,298		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | 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	52,126	0	52,126	0	52,126	1.00
2.00	Physician Assistant	4,932	0	4,932	0	4,932	2.00
3.00	Nurse Practitioner	95,433	0	95,433	0	95,433	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	84,613	0	84,613	0	84,613	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)	237,104	0	237,104	0	237,104	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	33,271	33,271	0	33,271	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,271	33,271	0	33,271	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	237,104	33,271	270,375	0	270,375	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	21,381	21,381	0	21,381	29.00
30.00	Administrative Costs	55,387	93,239	148,626	-67,241	81,385	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,387	114,620	170,007	-67,241	102,766	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	292,491	147,891	440,382	-67,241	373,141	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	52,126		1.00
2.00	Physician Assistant	0	4,932		2.00
3.00	Nurse Practitioner	0	95,433		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	84,613		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	237,104		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	33,271		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,271		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	270,375		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	21,381		29.00
30.00	Administrative Costs	0	81,385		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	102,766		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	373,141		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.25	572	4,200	1,050		1.00
2.00	Physician Assistant	0.91	2,258	2,100	1,911		2.00
3.00	Nurse Practitioner	0.01	31	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.17	2,861		2,982	2,982	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	0.03	58			58	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.20	2,919			3,040	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)					360,782	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)					360,782	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)					124,651	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					205,524	15.00
16.00	Total overhead (sum of lines 14 and 15)					330,175	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					330,175	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					330,175	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					690,957	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.76	8,831	4,200	11,592		1.00
2.00	Physician Assistant	2.13	4,861	2,100	4,473		2.00
3.00	Nurse Practitioner	0.87	1,935	2,100	1,827		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.76	15,627		17,892	17,892	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	0.06	12			12	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)	5.82	15,639			17,904	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,249,310	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,189	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,250,499	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999472	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					911,799	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,904,203	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,816,002	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,816,002	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,814,515	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,063,825	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.25	555	4,200	1,050		1.00
2.00	Physician Assistant	0.04	126	2,100	84		2.00
3.00	Nurse Practitioner	0.84	1,400	2,100	1,764		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.13	2,081		2,898	2,898	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.13	2,081			2,898	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)					270,375	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)					270,375	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)					102,766	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					436,322	15.00
16.00	Total overhead (sum of lines 14 and 15)					539,088	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					539,088	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					539,088	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					809,463	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/19/2018 12:50 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)			690,957	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			35,593	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			655,364	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,040	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)			3,040	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			215.58	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)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	215.58	215.58		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	430		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	92,699		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	92,699		16.00
16.01	Total program charges (see instructions)(from contractor's records)		94,481		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,251		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,171		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.)		62,567		16.04
16.05	Total program cost (see instructions)	0	66,738		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,319		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,982		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		66,738		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,931		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		77,669		22.00
23.00	Allowable bad debts (see instructions)		1,757		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,142		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		938		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)		78,811		26.00
26.01	Sequestration adjustment (see instructions)		1,576		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		49,546		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)		27,689		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/19/2018 12:50 pm
	Title XVIII	RHC II	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)			5,063,825	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			129,306	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,934,519	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,904	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)			17,904	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			275.61	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)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	275.61	275.61		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,131		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	862,935		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	862,935		16.00
16.01	Total program charges (see instructions)(from contractor's records)		679,886		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,606		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		26,154		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.)		618,722		16.04
16.05	Total program cost (see instructions)	0	644,876		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		63,378		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		119,181		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		644,876		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		39,689		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		684,565		22.00
23.00	Allowable bad debts (see instructions)		8,778		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,706		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,942		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)		690,271		26.00
26.01	Sequestration adjustment (see instructions)		13,805		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		646,618		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)		29,848		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/19/2018 12:50 pm
	Title XVIII	RHC III	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)		809,463	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		29,906	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		779,557	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,898	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)		2,898	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		269.00	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	269.00	269.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	331	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	89,039	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	89,039	16.00
16.01	Total program charges (see instructions)(from contractor's records)		66,173	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,542	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,420	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.)		61,914	16.04
16.05	Total program cost (see instructions)	0	65,334	16.05
17.00	Primary payer amounts		71	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,227	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,081	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		65,263	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,108	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		78,371	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)		78,371	26.00
26.01	Sequestration adjustment (see instructions)		1,567	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		101,052	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)		-24,248	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: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/19/2018 12:50 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)	316,627	316,627	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001876	0.002814	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	594	891	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,377	2,723	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,971	3,614	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	360,782	360,782	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	330,175	330,175	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.041496	0.010017	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,701	3,307	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	28,672	6,921	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	90	135	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	318.58	51.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	29	33	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,239	1,692	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)		35,593	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)		10,931	16.00

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

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,009,564	2,009,564	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001214	0.003052	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,440	6,133	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	35,034	13,830	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	37,474	19,963	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,249,310	2,249,310	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,814,515	2,814,515	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016660	0.008875	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	46,890	24,979	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	84,364	44,942	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	239	601	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	352.99	74.78	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	76	172	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	26,827	12,862	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)		129,306	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)		39,689	16.00

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

Provider CCN: 14-1301
Component CCN: 14-8566
Period: From 07/01/2017 To 06/30/2018
Worksheet M-4
Date/Time Prepared: 11/19/2018 12:50 pm

Title XVIII | RHC III | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	237,104	237,104	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001279	0.001816	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	303	431	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,726	1,529	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,029	1,960	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	270,375	270,375	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	539,088	539,088	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.029696	0.007249	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	16,009	3,908	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	24,038	5,868	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	50	71	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	480.76	82.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	24	19	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,538	1,570	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)		29,906	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)		13,108	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/19/2018 12:50 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		49,546	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)		49,546	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		27,689	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		77,235	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/19/2018 12:50 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		564,118	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		02/27/2018	82,500	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)		82,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		646,618	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		29,848	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		676,466	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-5 | Date/Time Prepared: 11/19/2018 12:50 pm

RHC III | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		45,152	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		02/27/2018	55,900	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)		55,900	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		101,052	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		24,248	6.02
7.00	Total Medicare program liability (see instructions)		76,804	7.00

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