State Copy

Health Financial Systems | WARNER HOSPITAL AND HEALTH SERVICES | In Lieu of Form CMS-2552-10

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: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/12/2018 4:04 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/12/2018 Time: 4:04 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: 09/27/2017
7. Contractor No. 06101
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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 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.

[ ] 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.

Encryption Information

ECR: Date: 9/12/2018 Time: 4:04 pm
p2ZawNMZktchEAcPZYYS1GWQ5EngF0
qkmNl0K.dH41pThipuigmDGIW9g2R6
tq9e0JQBsx0OMZ4d

PI: Date: 9/12/2018 Time: 4:04 pm
Tn5:ppDK5cboNMRtxId3wMP1LUfwI0
XG2770KmboWHZlZYadd0NxcYw4mffL
yoKM0nPAlK0e:kk:

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	173,564	307,893	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	6,053	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		11,226		0	10.00
200.00	Total	0	179,617	319,119	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2018 4:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 422 WEST WHITE STREET	PO Box:			1.00
2.00	City: CLINTON	State: IL	Zip Code: 61727	County: DEWITT	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	WARNER HOSPITAL AND HEALTH SERVICES	141303	99914	1	03/01/2000	N	O	O	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	SWING BED	14Z303	99914		03/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RURAL HEALTH CENTER	143404	99914		07/03/1995	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
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)	05/01/2017	04/30/2018	20.00
21.00	Type of Control (see instructions)	12		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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2018 4:03 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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/12/2018 4:03 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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/12/2018 4:03 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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/12/2018 4:03 pm

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	59,191	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)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/12/2018 4:03 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	Y	Y	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
161.10	CORF		N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40

		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)	05/01/2017	04/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 9/12/2018 4:03 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	08/14/2018	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.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/13/2018	Y	06/13/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/12/2018 4:03 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDDREW	MCCABE	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 9/12/2018 4:03 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.	CPA		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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 9/12/2018 4:03 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	15	5,475	10,160.45	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)		15	5,475	10,160.45	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)		15	5,475	10,160.45	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
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		15				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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/12/2018 4:03 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)	227	13	402			1.00
2.00	HMO and other (see instructions)	70	3				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	24	0	24			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	251	13	426			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)	251	13	426	0.00	106.77	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	5,766	2,474	15,931	0.00	23.43	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	130.20	27.00
28.00	Observation Bed Days		0	207			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/12/2018 4:03 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	85	10	163	1.00
2.00	HMO and other (see instructions)			18	2		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	85	10	163	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
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-8 | Date/Time Prepared: 9/12/2018 4:03 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			422 W WHITE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLINTON		IL	61727	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					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			07:30	19:00	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		DEWITT				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	19:00	07:30	19:00	07:30	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-8 | Date/Time Prepared: 9/12/2018 4:03 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	07:30	16:30	09:00	13:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-10 | Date/Time Prepared: 9/12/2018 4:03 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)	0.583445	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,790,745	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	5,412,307	6.00
7.00	Medicaid cost (line 1 times line 6)	3,157,783	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)	367,038	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)	367,038	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)	89,888	100,516	190,404	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	52,445	100,516	152,961	21.00
22.00	Payments received from patients for amounts previously written off as charity care	8,868	5,823	14,691	22.00
23.00	Cost of charity care (line 21 minus line 22)	43,577	94,693	138,270	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)	756,871	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	237,479	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	365,351	27.01
28.00	Non-Medicare bad debt expense (see instructions)	391,520	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	356,302	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	494,572	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	861,610	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/12/2018 4:03 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		363,194	363,194	42,008	405,202	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		579,772	579,772	16,237	596,009	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,970,272	1,970,272	-222,597	1,747,675	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,092,105	1,319,767	2,411,872	-2,414	2,409,458	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	201,012	606,051	807,063	0	807,063	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,678	85,678	0	85,678	8.00
9.00	00900	HOUSEKEEPING	117,968	31,573	149,541	0	149,541	9.00
10.00	01000	DIETARY	132,787	91,752	224,539	-148,893	75,646	10.00
11.00	01100	CAFETERIA	0	0	0	143,481	143,481	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	131,061	10,532	141,593	0	141,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,506	278,887	331,393	-272,893	58,500	14.00
15.00	01500	PHARMACY	138,642	702,174	840,816	-234,856	605,960	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,189	80,072	267,261	8,000	275,261	16.00
17.00	01700	SOCIAL SERVICE	43,456	2,326	45,782	0	45,782	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	167,766	167,766	0	167,766	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	632,438	144,892	777,330	27,849	805,179	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	181,084	130,044	311,128	4,401	315,529	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,283	485,506	816,789	2,118	818,907	54.00
60.00	06000	LABORATORY	378,524	528,041	906,565	7,526	914,091	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	7,214	7,214	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	76,524	76,524	64.00
65.00	06500	RESPIRATORY THERAPY	199,441	47,003	246,444	-23,539	222,905	65.00
66.00	06600	PHYSICAL THERAPY	0	465,459	465,459	-14,172	451,287	66.00
69.00	06900	ELECTROCARDIOLOGY	78,280	1,384	79,664	5,633	85,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	291,514	291,514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,973	52,973	0	52,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	234,856	234,856	73.00
76.00	03950	CARDIAC REHAB	76,306	10,789	87,095	5,000	92,095	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,811,931	300,185	2,112,116	83,366	2,195,482	88.00
90.00	09000	CLINIC	0	0	0	1,550	1,550	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	816,032	989,467	1,805,499	-24,822	1,780,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		27,366	27,366	-27,366	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,602,045	9,472,925	16,074,970	-14,275	16,060,695	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	62,395	3,154	65,549	103	65,652	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	14,172	14,172	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,664,440	9,476,079	16,140,519	0	16,140,519	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/12/2018 4:03 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	-21,913	383,289		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-18,108	577,901		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	759,019	2,506,694		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-49,126	2,360,332		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	807,063		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,678		8.00
9.00	00900	HOUSEKEEPING	0	149,541		9.00
10.00	01000	DIETARY	-12,685	62,961		10.00
11.00	01100	CAFETERIA	-31,260	112,221		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-332	141,261		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,500		14.00
15.00	01500	PHARMACY	-169,004	436,956		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,223	267,038		16.00
17.00	01700	SOCIAL SERVICE	0	45,782		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	167,766		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-201,010	604,169		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-89,092	226,437		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	818,907		54.00
60.00	06000	LABORATORY	0	914,091		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,214		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	76,524		64.00
65.00	06500	RESPIRATORY THERAPY	-775	222,130		65.00
66.00	06600	PHYSICAL THERAPY	-6,668	444,619		66.00
69.00	06900	ELECTROCARDIOLOGY	-25,258	60,039		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-2	291,512		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,984	229,872		73.00
76.00	03950	CARDIAC REHAB	-175	91,920		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-51,680	2,143,802		88.00
90.00	09000	CLINIC	0	1,550		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	1,780,677		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,724	16,129,419		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	65,652		192.00
192.01	19201	LIFELINE	0	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0		192.02
192.03	19203	COMMUNITY BENEFIT	0	14,172		192.03
192.04	19204	RENTAL PROPERTIES	0	0		192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	68,724	16,209,243		200.00

RECLASSIFICATIONS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/12/2018 4:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA COSTS FROM DIET				
1.00	CAFETERIA	11.00	84,851	58,630	1.00
2.00	EMERGENCY	91.00	598	413	2.00
3.00	OPERATING ROOM	50.00	2,603	1,798	3.00
	TOTALS		88,052	60,841	
	B - TO RECLASS DRUGS SOLD TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	234,856	1.00
	TOTALS		0	234,856	
	C - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,100	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,266	2.00
	TOTALS		0	27,366	
	D - TO RECLASS SUPPLIES CHARGED TO PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	267,575	1.00
	TOTALS		0	267,575	
	F - TO RECLSS PROPERTY INS EXP				
1.00	OTHER CAP REL COSTS	3.00	0	30,982	1.00
	TOTALS		0	30,982	
	G - TO RECLASS RHC ADMIN EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,382	1.00
	TOTALS		0	43,382	
	H - TO RECLASS OXYGEN SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,939	1.00
	TOTALS		0	23,939	
	I - TO RECLASS NURSING COST				
1.00	INTRAVENOUS THERAPY	64.00	76,524	0	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	7,214	0	2.00
3.00	CLINIC	90.00	1,550	0	3.00
	TOTALS		85,288	0	
	J - TO RECLASS GRANT EXPENSES				
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,000	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,000	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	9,250	3.00
4.00	EMERGENCY	91.00	0	4,494	4.00
	TOTALS		0	21,744	
	K - TO RECLASS RHC PHYSICIAN TIME				
1.00	ADULTS & PEDIATRICS	30.00	68,216	13,994	1.00
2.00	ELECTROCARDIOLOGY	69.00	5,022	611	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	8,182	1,548	3.00
	TOTALS		81,420	16,153	
	L - TO RECLASS ATHLETIC TRAINER COM BEN				
1.00	COMMUNITY BENEFIT	192.03	0	14,172	1.00
	TOTALS		0	14,172	
	N - TO RECLASS RHC LAB TESTS				
1.00	LABORATORY	60.00	7,526	0	1.00
	TOTALS		7,526	0	
	O - TO RECLASS RESTRICTED DONATIONS				
1.00	ADULTS & PEDIATRICS	30.00	0	600	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,118	2.00
3.00	RESPIRATORY THERAPY	65.00	0	400	3.00
4.00	CARDIAC REHAB	76.00	0	5,000	4.00
	TOTALS		0	8,118	
	P - OP CLINIC MME DEPRECIATION				
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	103	1.00
	TOTALS		0	103	
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	222,597	1.00
	TOTALS		0	222,597	
	R - CELLPHONE EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,318	1.00
	TOTALS		0	5,318	
500.00	Grand Total: Increases		262,286	977,146	500.00

RECLASSIFICATIONS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/12/2018 4:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS FROM DIET						
1.00	DIETARY	10.00	88,052	60,841	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		88,052	60,841			
	B - TO RECLASS DRUGS SOLD TO PATIENTS						
1.00	PHARMACY	15.00	0	234,856	0		1.00
	TOTALS		0	234,856			
	C - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	27,366	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	27,366			
	D - TO RECLASS SUPPLIES CHARGED TO PTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	267,575	0		1.00
	TOTALS		0	267,575			
	F - TO RECLSS PROPERTY INS EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,982	12		1.00
	TOTALS		0	30,982			
	G - TO RECLASS RHC ADMIN EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	43,382	0		1.00
	TOTALS		0	43,382			
	H - TO RECLASS OXYGEN SUPPLIES						
1.00	RESPIRATORY THERAPY	65.00	0	23,939	0		1.00
	TOTALS		0	23,939			
	I - TO RECLASS NURSING COST						
1.00	ADULTS & PEDIATRICS	30.00	54,961	0	0		1.00
2.00	EMERGENCY	91.00	30,327	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		85,288	0			
	J - TO RECLASS GRANT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,744	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	21,744			
	K - TO RECLASS RHC PHYSICIAN TIME						
1.00	RURAL HEALTH CLINIC	88.00	81,420	16,153	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		81,420	16,153			
	L - TO RECLASS ATHLETIC TRAINER COM BEN						
1.00	PHYSICAL THERAPY	66.00	0	14,172	0		1.00
	TOTALS		0	14,172			
	N - TO RECLASS RHC LAB TESTS						
1.00	RURAL HEALTH CLINIC	88.00	7,526	0	0		1.00
	TOTALS		7,526	0			
	O - TO RECLASS RESTRICTED DONATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,118	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	8,118			
	P - OP CLINIC MME DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	103	9		1.00
	TOTALS		0	103			
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	222,597	0		1.00
	TOTALS		0	222,597			
	R - CELLPHONE EXPENSES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,318	0		1.00
	TOTALS		0	5,318			
500.00	Grand Total: Decreases		262,286	977,146			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 9/12/2018 4:03 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	343,588	78,580	0	78,580	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,945,258	160,560	0	160,560	61,714	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	125,772	15,260	0	15,260	12,521	5.00
6.00	Movable Equipment	5,238,765	771,952	0	771,952	550,526	6.00
7.00	HIT designated Assets	1,104,343	0	0	0	63,089	7.00
8.00	Subtotal (sum of lines 1-7)	17,757,726	1,026,352	0	1,026,352	687,850	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,757,726	1,026,352	0	1,026,352	687,850	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	422,168	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	11,044,104	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	128,511	0	5.00
6.00	Movable Equipment	5,460,191	0	6.00
7.00	HIT designated Assets	1,041,254	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,096,228	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,096,228	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 9/12/2018 4:03 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	363,194	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	579,772	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	942,966	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	363,194		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	579,772		2.00
3.00	Total (sum of lines 1-2)	0	942,966		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 9/12/2018 4:03 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	11,044,104	0	11,044,104	0.610299	18,908	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,052,124	0	7,052,124	0.389701	12,074	2.00
3.00	Total (sum of lines 1-2)	18,096,228	0	18,096,228	1.000000	30,982	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	18,908	363,194	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	12,074	565,608	0	2.00
3.00	Total (sum of lines 1-2)	0	0	30,982	928,802	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	1,187	18,908	0	0	383,289	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	219	12,074	0	0	577,901	2.00
3.00	Total (sum of lines 1-2)	1,406	30,982	0	0	961,190	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/12/2018 4:03 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	-21,913	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4,047	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-1,357	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	-315,360			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	65,777			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,260	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,984	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,223	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,310	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-6,794	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	-7,352	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/12/2018 4:03 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	
34.00	OUTSIDE DIETARY SERVICES	B	-11,375	DIETARY	10.00	0	34.00
35.00	RESTING METABOLIC INCOME	B	-775	RESPIRATORY THERAPY	65.00	0	35.00
36.00	FITNESS MGMT	B	-6,105	PHYSICAL THERAPY	66.00	0	36.00
37.00	NON-ALLOW AMORTIZATION	A	-50,000	RURAL HEALTH CLINIC	88.00	0	37.00
38.00	EHR DEPRECIATION - CAPITAL LEAS	A	-7,267	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
39.00	OTHER REVENUE - RHC	B	-1,680	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	PEACE MEAL STAFF TIME	A	-431	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	LOBBYING EXPENSE	A	-7,411	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING AND MARKETING	A	-71,750	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	NON-ALLOWABLE PT PURCHASED SERVICE	A	-563	PHYSICAL THERAPY	66.00	0	43.00
44.00	CLINICAL TRAINING CLASSES	B	-332	NURSING ADMINISTRATION	13.00	0	44.00
45.00	PENSION DIFFERENTIAL	A	759,019	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00	340B PROGRAM EXPENSES	A	-169,004	PHARMACY	15.00	0	46.00
47.00	OTHER REVENUE - CARDIAC REHAB	B	-175	CARDIAC REHAB	76.00	0	47.00
48.00	NON-ALLOWABLE CONTRIBUTIONS	A	-5,506	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	INTEREST FROM INSURANCE COMPANIES	B	-21,096	ADMINISTRATIVE & GENERAL	5.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		68,724				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 9/12/2018 4:03 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	65,777	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			65,777	0	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	CITY OF CLINTON	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 9/12/2018 4:03 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	65,777	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	65,777			5.00

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

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

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

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

6.00	CITY GOVERNMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 9/12/2018 4:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	740	0	740	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	25,258	25,258	0	0	0	2.00
3.00	50.00	OPERATING ROOM	89,092	89,092	0	0	0	3.00
4.00	91.00	EMERGENCY	930,567	0	930,567	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	201,010	201,010	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	9,730	0	9,730	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,256,397	315,360	941,037		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	25,258		2.00
3.00	50.00	OPERATING ROOM	0	0	0	89,092		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	201,010		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	315,360		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/12/2018 4:03 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					270	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.54	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,408.50	2,699.25	1,255.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.19	60.89	13.78	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.60	40.60	30.45			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)					276,736	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					164,357	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					441,093	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					17,294	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)					458,387	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					458,387	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)					10,962	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)					10,962	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,499	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,461	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)					12,461	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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/12/2018 4:03 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.19	60.89	13.78	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)	458,387		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,461		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)	470,848		63.00
64.00	Total cost of outside supplier services (from your records)	269,132		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	10,962		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,499		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,461		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,499		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,499		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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	383,289	383,289				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	577,901		577,901			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,506,694	2,300	3,712	2,512,706		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,360,332	42,629	68,785	504,727	2,976,473	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	807,063	74,537	120,271	92,900	1,094,771	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,678	4,540	7,326	0	97,544	8.00
9.00	00900	HOUSEKEEPING	149,541	2,251	3,632	54,520	209,944	9.00
10.00	01000	DIETARY	62,961	11,876	19,163	20,675	114,675	10.00
11.00	01100	CAFETERIA	112,221	0	0	39,215	151,436	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	141,261	1,998	3,223	60,571	207,053	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,500	7,743	12,494	24,266	103,003	14.00
15.00	01500	PHARMACY	436,956	6,604	10,656	64,075	518,291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	267,038	8,552	13,800	86,511	375,901	16.00
17.00	01700	SOCIAL SERVICE	45,782	0	0	20,084	65,866	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	167,766	0	0	0	167,766	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	604,169	44,450	71,725	266,887	987,231	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	226,437	26,416	42,625	84,893	380,371	50.00
53.00	05300	ANESTHESIOLOGY	0	985	1,590	0	2,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	818,907	26,592	42,909	153,106	1,041,514	54.00
60.00	06000	LABORATORY	914,091	9,213	14,865	178,417	1,116,586	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,214	0	0	3,334	10,548	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	76,524	1,216	1,963	35,366	115,069	64.00
65.00	06500	RESPIRATORY THERAPY	222,130	2,256	3,641	92,174	320,201	65.00
66.00	06600	PHYSICAL THERAPY	444,619	13,830	22,316	0	480,765	66.00
69.00	06900	ELECTROCARDIOLOGY	60,039	1,348	2,176	36,178	99,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,512	0	0	0	291,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,973	0	0	0	52,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	229,872	0	0	0	229,872	73.00
76.00	03950	CARDIAC REHAB	91,920	1,805	2,913	35,266	131,904	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,143,802	47,246	76,236	266,591	2,533,875	88.00
90.00	09000	CLINIC	1,550	0	0	716	2,266	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,780,677	19,757	31,880	363,398	2,195,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,129,419	358,144	577,901	2,483,870	16,075,438	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	65,652	25,145	0	28,836	119,633	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	14,172	0	0	0	14,172	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,209,243	383,289	577,901	2,512,706	16,209,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/12/2018 4:03 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	2,976,473					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	246,249	0	1,341,020			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,941	0	23,078	142,563		8.00
9.00	00900	HOUSEKEEPING	47,223	0	11,441	0	268,608	9.00
10.00	01000	DIETARY	25,794	0	60,367	0	12,411	10.00
11.00	01100	CAFETERIA	34,063	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	46,573	0	10,154	0	2,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,169	0	39,359	0	8,092	14.00
15.00	01500	PHARMACY	116,580	0	33,568	0	6,901	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,552	0	43,471	0	8,937	16.00
17.00	01700	SOCIAL SERVICE	14,815	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	37,736	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	222,060	0	225,942	142,563	46,452	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,558	0	134,273	0	27,606	50.00
53.00	05300	ANESTHESIOLOGY	579	0	5,007	0	1,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	234,270	0	135,168	0	27,790	54.00
60.00	06000	LABORATORY	251,156	0	46,828	0	9,627	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,373	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	25,883	0	6,182	0	1,271	64.00
65.00	06500	RESPIRATORY THERAPY	72,023	0	11,469	0	2,358	65.00
66.00	06600	PHYSICAL THERAPY	108,139	0	70,297	0	14,453	66.00
69.00	06900	ELECTROCARDIOLOGY	22,435	0	6,853	0	1,409	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,570	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,915	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,706	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	29,669	0	9,175	0	1,886	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	569,949	0	240,152	0	49,374	88.00
90.00	09000	CLINIC	510	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	493,886	0	100,425	0	20,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,946,376	0	1,213,209	142,563	242,331	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	26,909	0	127,811	0	26,277	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	3,188	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	2,976,473	0	1,341,020	142,563	268,608	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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	213,247					10.00
11.00	01100	CAFETERIA	0	185,499				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	4,753	0	270,621		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,904	0	0	175,527	14.00
15.00	01500	PHARMACY	0	5,027	0	0	783	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,788	0	0	13	16.00
17.00	01700	SOCIAL SERVICE	0	1,576	0	6,445	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	162	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	213,247	23,414	0	86,192	5,156	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,661	0	16,742	7,974	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,013	0	0	12,616	54.00
60.00	06000	LABORATORY	0	13,999	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	262	0	1,068	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	2,775	0	11,332	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,232	0	0	971	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	902	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,021	0	0	457	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	105,788	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,943	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,767	0	11,292	665	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	62,475	0	30,280	5,314	88.00
90.00	09000	CLINIC	0	56	0	230	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	28,513	0	101,208	13,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,247	183,236	0	264,789	175,256	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,263	0	5,832	271	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	213,247	185,499	0	270,621	175,527	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	681,150					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	519,662				16.00
17.00	01700	SOCIAL SERVICE	0	0	88,702			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	205,664		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	13,783	88,702	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,537	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	11,329	0	205,664	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,828	0	0	0	54.00
60.00	06000	LABORATORY	0	95,262	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,111	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	24,144	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,665	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	46,843	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,092	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,097	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,762	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	631,785	21,551	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	5,023	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	49,365	59,059	0	0	0	88.00
90.00	09000	CLINIC	0	233	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	68,343	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	681,150	519,662	88,702	205,664	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	681,150	519,662	88,702	205,664	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,054,742	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	680,722	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	226,183	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,581,199	0	54.00
60.00	06000	LABORATORY	0	0	0	1,533,458	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	15,362	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	186,656	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	422,919	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	721,399	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	143,008	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	476,967	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	87,593	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	934,914	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	192,381	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,599,843	0	88.00
90.00	09000	CLINIC	0	0	0	3,295	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	3,022,246	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	15,882,887	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	308,996	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	17,360	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	16,209,243	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,054,742		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	680,722		50.00
53.00	05300	ANESTHESIOLOGY	226,183		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,199		54.00
60.00	06000	LABORATORY	1,533,458		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,362		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	186,656		64.00
65.00	06500	RESPIRATORY THERAPY	422,919		65.00
66.00	06600	PHYSICAL THERAPY	721,399		66.00
69.00	06900	ELECTROCARDIOLOGY	143,008		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	476,967		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,593		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	934,914		73.00
76.00	03950	CARDIAC REHAB	192,381		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	3,599,843		88.00
90.00	09000	CLINIC	3,295		90.00
90.01	09001	PROVIDER BASED CLINIC	0		90.01
91.00	09100	EMERGENCY	3,022,246		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,882,887		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	308,996		192.00
192.01	19201	LIFELINE	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0		192.02
192.03	19203	COMMUNITY BENEFIT	17,360		192.03
192.04	19204	RENTAL PROPERTIES	0		192.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	16,209,243		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,300	3,712	6,012	6,012	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	42,629	68,785	111,414	1,207	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	74,537	120,271	194,808	222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,540	7,326	11,866	0	8.00
9.00	00900	HOUSEKEEPING	0	2,251	3,632	5,883	130	9.00
10.00	01000	DIETARY	0	11,876	19,163	31,039	49	10.00
11.00	01100	CAFETERIA	0	0	0	0	94	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,998	3,223	5,221	145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,743	12,494	20,237	58	14.00
15.00	01500	PHARMACY	0	6,604	10,656	17,260	153	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,552	13,800	22,352	207	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	48	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	44,450	71,725	116,175	639	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,416	42,625	69,041	203	50.00
53.00	05300	ANESTHESIOLOGY	0	985	1,590	2,575	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,592	42,909	69,501	366	54.00
60.00	06000	LABORATORY	0	9,213	14,865	24,078	427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	8	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,216	1,963	3,179	85	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,256	3,641	5,897	221	65.00
66.00	06600	PHYSICAL THERAPY	0	13,830	22,316	36,146	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,348	2,176	3,524	87	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	1,805	2,913	4,718	84	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	47,246	76,236	123,482	638	88.00
90.00	09000	CLINIC	0	0	0	0	2	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	19,757	31,880	51,637	870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	358,144	577,901	936,045	5,943	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	25,145	0	25,145	69	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	383,289	577,901	961,190	6,012	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/12/2018 4:03 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	112,621					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	9,318	0	204,348			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	830	0	3,517	16,213		8.00
9.00	00900	HOUSEKEEPING	1,787	0	1,743	0	9,543	9.00
10.00	01000	DIETARY	976	0	9,199	0	441	10.00
11.00	01100	CAFETERIA	1,289	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,762	0	1,547	0	74	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	877	0	5,998	0	287	14.00
15.00	01500	PHARMACY	4,411	0	5,115	0	245	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,199	0	6,624	0	318	16.00
17.00	01700	SOCIAL SERVICE	561	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,428	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,402	0	34,430	16,213	1,650	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,237	0	20,461	0	981	50.00
53.00	05300	ANESTHESIOLOGY	22	0	763	0	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,864	0	20,597	0	987	54.00
60.00	06000	LABORATORY	9,503	0	7,136	0	342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	90	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	979	0	942	0	45	64.00
65.00	06500	RESPIRATORY THERAPY	2,725	0	1,748	0	84	65.00
66.00	06600	PHYSICAL THERAPY	4,092	0	10,712	0	513	66.00
69.00	06900	ELECTROCARDIOLOGY	849	0	1,044	0	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,481	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	451	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,956	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,123	0	1,398	0	67	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,563	0	36,595	0	1,754	88.00
90.00	09000	CLINIC	19	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	18,688	0	15,303	0	734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,482	0	184,872	16,213	8,609	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,018	0	19,476	0	934	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	121	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	112,621	0	204,348	16,213	9,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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	41,704					10.00
11.00	01100	CAFETERIA	0	1,383				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	35	0	8,784		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14	0	0	27,471	14.00
15.00	01500	PHARMACY	0	37	0	0	123	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	12	0	209	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	25	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,704	174	0	2,798	807	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50	0	543	1,248	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	89	0	0	1,975	54.00
60.00	06000	LABORATORY	0	104	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2	0	35	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	21	0	368	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	54	0	0	152	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	141	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22	0	0	72	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	16,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	21	0	367	104	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	468	0	983	832	88.00
90.00	09000	CLINIC	0	0	0	7	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	212	0	3,285	2,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,704	1,366	0	8,595	27,429	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	17	0	189	42	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	41,704	1,383	0	8,784	27,471	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	27,344					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,753				16.00
17.00	01700	SOCIAL SERVICE	0	0	830			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,453		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	869	830			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,357	0			50.00
53.00	05300	ANESTHESIOLOGY	0	714	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,429	0			54.00
60.00	06000	LABORATORY	0	6,003	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	70	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,522	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	546	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,952	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	573	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	888	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	111	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,362	1,358	0			73.00
76.00	03950	CARDIAC REHAB	0	317	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,982	3,722	0			88.00
90.00	09000	CLINIC	0	15	0			90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0			90.01
91.00	09100	EMERGENCY	0	4,307	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,344	32,753	830	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	LIFELINE	0	0	0			192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0			192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0			192.03
192.04	19204	RENTAL PROPERTIES	0	0	0			192.04
200.00		Cross Foot Adjustments				1,453	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,344	32,753	830	1,453	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				224,691	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				97,121	0	50.00
53.00	05300	ANESTHESIOLOGY				4,111	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				109,808	0	54.00
60.00	06000	LABORATORY				47,593	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				205	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				7,141	0	64.00
65.00	06500	RESPIRATORY THERAPY				11,427	0	65.00
66.00	06600	PHYSICAL THERAPY				54,556	0	66.00
69.00	06900	ELECTROCARDIOLOGY				6,221	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				19,924	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				3,840	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				28,676	0	73.00
76.00	03950	CARDIAC REHAB				8,199	0	76.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				192,019	0	88.00
90.00	09000	CLINIC				43	0	90.00
90.01	09001	PROVIDER BASED CLINIC				0	0	90.01
91.00	09100	EMERGENCY				97,151	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	912,726	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES				46,890	0	192.00
192.01	19201	LIFELINE				0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT				0	0	192.02
192.03	19203	COMMUNITY BENEFIT				121	0	192.03
192.04	19204	RENTAL PROPERTIES				0	0	192.04
200.00		Cross Foot Adjustments	0	0	0	1,453	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	961,190	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	224,691		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	97,121		50.00
53.00	05300	ANESTHESIOLOGY	4,111		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,808		54.00
60.00	06000	LABORATORY	47,593		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	205		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	7,141		64.00
65.00	06500	RESPIRATORY THERAPY	11,427		65.00
66.00	06600	PHYSICAL THERAPY	54,556		66.00
69.00	06900	ELECTROCARDIOLOGY	6,221		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,924		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,840		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,676		73.00
76.00	03950	CARDIAC REHAB	8,199		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	192,019		88.00
90.00	09000	CLINIC	43		90.00
90.01	09001	PROVIDER BASED CLINIC	0		90.01
91.00	09100	EMERGENCY	97,151		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	912,726		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	46,890		192.00
192.01	19201	LIFELINE	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0		192.02
192.03	19203	COMMUNITY BENEFIT	121		192.03
192.04	19204	RENTAL PROPERTIES	0		192.04
200.00		Cross Foot Adjustments	1,453		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	961,190		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	69,647					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		65,078				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	418	418	5,436,871			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,746	7,746	1,092,105	-2,976,473	13,232,770	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,544	13,544	201,012	0	1,094,771	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	825	825	0	0	97,544	8.00
9.00	00900	HOUSEKEEPING	409	409	117,968	0	209,944	9.00
10.00	01000	DIETARY	2,158	2,158	44,735	0	114,675	10.00
11.00	01100	CAFETERIA	0	0	84,851	0	151,436	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	363	363	131,061	0	207,053	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,407	1,407	52,506	0	103,003	14.00
15.00	01500	PHARMACY	1,200	1,200	138,642	0	518,291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,554	1,554	187,189	0	375,901	16.00
17.00	01700	SOCIAL SERVICE	0	0	43,456	0	65,866	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	167,766	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,077	8,077	577,477	0	987,231	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,800	4,800	183,687	0	380,371	50.00
53.00	05300	ANESTHESIOLOGY	179	179	0	0	2,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,832	4,832	331,283	0	1,041,514	54.00
60.00	06000	LABORATORY	1,674	1,674	386,050	0	1,116,586	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	7,214	0	10,548	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	221	221	76,524	0	115,069	64.00
65.00	06500	RESPIRATORY THERAPY	410	410	199,441	0	320,201	65.00
66.00	06600	PHYSICAL THERAPY	2,513	2,513	0	0	480,765	66.00
69.00	06900	ELECTROCARDIOLOGY	245	245	78,280	0	99,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	291,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	52,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	229,872	73.00
76.00	03950	CARDIAC REHAB	328	328	76,306	0	131,904	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,585	8,585	576,836	0	2,533,875	88.00
90.00	09000	CLINIC	0	0	1,550	0	2,266	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,590	3,590	786,303	0	2,195,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,078	65,078	5,374,476	-2,976,473	13,098,965	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,569	0	62,395	0	119,633	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	14,172	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	383,289	577,901	2,512,706		2,976,473	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.503310	8.880128	0.462160		0.224932	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,012		112,621	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001106		0.008511	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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			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	0					6.00
7.00	00700	OPERATION OF PLANT	0	47,939				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	825	636			8.00
9.00	00900	HOUSEKEEPING	0	409	0	46,705		9.00
10.00	01000	DIETARY	0	2,158	0	2,158	636	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	363	0	363	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,407	0	1,407	0	14.00
15.00	01500	PHARMACY	0	1,200	0	1,200	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,554	0	1,554	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,077	636	8,077	636	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,800	0	4,800	0	50.00
53.00	05300	ANESTHESIOLOGY	0	179	0	179	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,832	0	4,832	0	54.00
60.00	06000	LABORATORY	0	1,674	0	1,674	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	221	0	221	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	410	0	410	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,513	0	2,513	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	245	0	245	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	328	0	328	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,585	0	8,585	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	3,590	0	3,590	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	43,370	636	42,136	636	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4,569	0	4,569	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	0	1,341,020	142,563	268,608	213,247	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.973466	224.155660	5.751162	335.294025	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204,348	16,213	9,543	41,704	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.262667	25.492138	0.204325	65.572327	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		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	5,115,587					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	131,061	0	1,827,487			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,506	0	0	443,970		14.00
15.00	01500	PHARMACY	138,642	0	0	1,980	435,416	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,189	0	0	32	0	16.00
17.00	01700	SOCIAL SERVICE	43,456	0	43,524	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	410	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	645,693	0	582,049	13,041	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,687	0	113,059	20,169	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,283	0	0	31,911	0	54.00
60.00	06000	LABORATORY	386,050	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,214	0	7,214	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	76,524	0	76,524	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	199,441	0	0	2,457	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,282	0	66.00
69.00	06900	ELECTROCARDIOLOGY	83,302	0	0	1,156	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	267,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,973	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	403,860	73.00
76.00	03950	CARDIAC REHAB	76,306	0	76,254	1,683	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,722,985	0	204,478	13,440	31,556	88.00
90.00	09000	CLINIC	1,550	0	1,550	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	786,303	0	683,449	34,176	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,053,192	0	1,788,101	443,285	435,416	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	62,395	0	39,386	685	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	185,499	0	270,621	175,527	681,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.036262	0.000000	0.148084	0.395358	1.564366	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,383	0	8,784	27,471	27,344	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000270	0.000000	0.004807	0.061876	0.062800	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,222,610					16.00
17.00	01700	SOCIAL SERVICE	0	636				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	722,051	636	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,128,245	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	593,502	0	100	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,172,025	0	0	0	0	54.00
60.00	06000	LABORATORY	4,990,395	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,195	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,264,830	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	453,911	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,453,952	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	476,276	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	738,511	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,292	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,128,975	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	263,159	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,093,869	0	0	0	0	88.00
90.00	09000	CLINIC	12,194	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,580,228	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,222,610	636	100	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	519,662	88,702	205,664	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019089	139.468553	2,056.640000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,753	830	1,453	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001203	1.305031	14.530000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
		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
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	LIFELINE	0	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0		192.02
192.03	19203	COMMUNITY BENEFIT	0	0		192.03
192.04	19204	RENTAL PROPERTIES	0	0		192.04
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)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)			
			22.00	23.00			
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000			205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,054,742		2,054,742	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	680,722		680,722	0	0	50.00
53.00	05300	ANESTHESIOLOGY	226,183		226,183	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,199		1,581,199	0	0	54.00
60.00	06000	LABORATORY	1,533,458		1,533,458	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,362		15,362	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	186,656		186,656	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	422,919	0	422,919	0	0	65.00
66.00	06600	PHYSICAL THERAPY	721,399	0	721,399	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	143,008		143,008	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	476,967		476,967	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,593		87,593	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	934,914		934,914	0	0	73.00
76.00	03950	CARDIAC REHAB	192,381		192,381	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,599,843		3,599,843	0	0	88.00
90.00	09000	CLINIC	3,295		3,295	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	3,022,246		3,022,246	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	671,930		671,930		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,554,817	0	16,554,817	0	0	200.00
201.00		Less Observation Beds	671,930		671,930		0	201.00
202.00		Total (see instructions)	15,882,887	0	15,882,887	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 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	473,864		473,864			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	271,198	857,047	1,128,245	0.603346	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	160,503	432,999	593,502	0.381099	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,175	5,748,850	6,172,025	0.256188	0.000000	54.00
60.00	06000	LABORATORY	345,957	4,644,438	4,990,395	0.307282	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	905	57,290	58,195	0.263975	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	102,590	1,162,240	1,264,830	0.147574	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	154,317	299,594	453,911	0.931722	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,796	2,438,156	2,453,952	0.293974	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	37,532	438,744	476,276	0.300263	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	423,343	315,168	738,511	0.645850	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,791	76,501	92,292	0.949086	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,197	884,778	1,128,975	0.828109	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	263,159	263,159	0.731045	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,093,869	3,093,869			88.00
90.00	09000	CLINIC	0	12,194	12,194	0.270215	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	141,940	3,438,288	3,580,228	0.844149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	26,122	222,065	248,187	2.707354	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,837,230	24,385,380	27,222,610			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,837,230	24,385,380	27,222,610			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 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
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	CARDIAC REHAB	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,054,742		2,054,742	0	2,054,742	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	680,722		680,722	0	680,722	50.00
53.00	05300	ANESTHESIOLOGY	226,183		226,183	0	226,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,199		1,581,199	0	1,581,199	54.00
60.00	06000	LABORATORY	1,533,458		1,533,458	0	1,533,458	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,362		15,362	0	15,362	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	186,656		186,656	0	186,656	64.00
65.00	06500	RESPIRATORY THERAPY	422,919	0	422,919	0	422,919	65.00
66.00	06600	PHYSICAL THERAPY	721,399	0	721,399	0	721,399	66.00
69.00	06900	ELECTROCARDIOLOGY	143,008		143,008	0	143,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	476,967		476,967	0	476,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,593		87,593	0	87,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	934,914		934,914	0	934,914	73.00
76.00	03950	CARDIAC REHAB	192,381		192,381	0	192,381	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,599,843		3,599,843	0	3,599,843	88.00
90.00	09000	CLINIC	3,295		3,295	0	3,295	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	3,022,246		3,022,246	0	3,022,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	671,930		671,930		671,930	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,554,817	0	16,554,817	0	16,554,817	200.00
201.00		Less Observation Beds	671,930		671,930		671,930	201.00
202.00		Total (see instructions)	15,882,887	0	15,882,887	0	15,882,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | 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	473,864		473,864			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	271,198	857,047	1,128,245	0.603346	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	160,503	432,999	593,502	0.381099	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,175	5,748,850	6,172,025	0.256188	0.000000	54.00
60.00	06000	LABORATORY	345,957	4,644,438	4,990,395	0.307282	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	905	57,290	58,195	0.263975	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	102,590	1,162,240	1,264,830	0.147574	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	154,317	299,594	453,911	0.931722	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,796	2,438,156	2,453,952	0.293974	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	37,532	438,744	476,276	0.300263	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	423,343	315,168	738,511	0.645850	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,791	76,501	92,292	0.949086	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,197	884,778	1,128,975	0.828109	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	263,159	263,159	0.731045	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,093,869	3,093,869	1.163541	0.000000	88.00
90.00	09000	CLINIC	0	12,194	12,194	0.270215	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	141,940	3,438,288	3,580,228	0.844149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	26,122	222,065	248,187	2.707354	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,837,230	24,385,380	27,222,610			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,837,230	24,385,380	27,222,610			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | 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
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	CARDIAC REHAB	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 9/12/2018 4:03 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	97,121	1,128,245	0.086081	54,745	4,713	50.00
53.00	05300	ANESTHESIOLOGY	4,111	593,502	0.006927	29,886	207	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,808	6,172,025	0.017791	123,563	2,198	54.00
60.00	06000	LABORATORY	47,593	4,990,395	0.009537	120,639	1,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	205	58,195	0.003523	905	3	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	7,141	1,264,830	0.005646	6,739	38	64.00
65.00	06500	RESPIRATORY THERAPY	11,427	453,911	0.025175	81,867	2,061	65.00
66.00	06600	PHYSICAL THERAPY	54,556	2,453,952	0.022232	9,750	217	66.00
69.00	06900	ELECTROCARDIOLOGY	6,221	476,276	0.013062	13,115	171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,924	738,511	0.026979	69,518	1,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,840	92,292	0.041607	10,527	438	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,676	1,128,975	0.025400	97,945	2,488	73.00
76.00	03950	CARDIAC REHAB	8,199	263,159	0.031156	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	192,019	3,093,869	0.062064	0	0	88.00
90.00	09000	CLINIC	43	12,194	0.003526	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	97,151	3,580,228	0.027135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,477	248,187	0.296055	0	0	92.00
200.00		Total (lines 50 through 199)	761,512	26,748,746		619,199	15,561	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/12/2018 4:03 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	25,091	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	25,091	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/12/2018 4:03 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	1,128,245	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	25,091	0	593,502	0.042276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,172,025	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,990,395	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	58,195	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,264,830	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	453,911	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,453,952	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	476,276	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	738,511	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	92,292	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,128,975	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	263,159	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,093,869	0.000000	88.00
90.00	09000	CLINIC	0	0	0	12,194	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	3,580,228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	248,187	0.000000	92.00
200.00		Total (lines 50 through 199)	0	25,091	0	26,748,746		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/12/2018 4:03 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	54,745	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	29,886	1,263	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	123,563	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	120,639	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	905	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	6,739	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	81,867	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	9,750	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,115	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	69,518	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,527	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	97,945	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		619,199	1,263	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/12/2018 4:03 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	0.603346	0	356,719	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.381099	0	173,516	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256188	0	2,148,556	0	0	54.00
60.00	06000	LABORATORY	0.307282	0	1,965,609	584	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.263975	0	24,866	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.147574	0	659,053	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.931722	0	120,512	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.293974	0	751,082	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300263	0	192,748	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.645850	0	127,074	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.949086	0	41,210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.828109	0	454,912	0	0	73.00
76.00	03950	CARDIAC REHAB	0.731045	0	127,096	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.270215	0	1,693	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.844149	0	952,757	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.707354	0	136,627	0	0	92.00
200.00		Subtotal (see instructions)		0	8,234,030	584	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	8,234,030	584	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/12/2018 4:03 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	215,225	0		50.00
53.00	05300	ANESTHESIOLOGY	66,127	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	550,434	0		54.00
60.00	06000	LABORATORY	603,996	179		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,564	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	97,259	0		64.00
65.00	06500	RESPIRATORY THERAPY	112,284	0		65.00
66.00	06600	PHYSICAL THERAPY	220,799	0		66.00
69.00	06900	ELECTROCARDIOLOGY	57,875	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	82,071	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,112	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	376,717	0		73.00
76.00	03950	CARDIAC REHAB	92,913	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	457	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	804,269	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	369,898	0		92.00
200.00		Subtotal (see instructions)	3,696,000	179		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,696,000	179		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V | Date/Time Prepared: 9/12/2018 4:03 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	0.603346	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.381099	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256188	0	0	0	0	54.00
60.00	06000	LABORATORY	0.307282	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.263975	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.147574	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.931722	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.293974	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300263	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.645850	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.949086	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.828109	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.731045	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.270215	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.844149	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.707354	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V | Date/Time Prepared: 9/12/2018 4:03 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
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 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)	633	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	609	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)	402	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	16	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)	8	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	227	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)	16	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)	8	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	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,054,742	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	77,905	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,976,837	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)	1,976,837	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)	3,246.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	736,851	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)	736,851	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 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)	333,458	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,070,309	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)	51,937	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	25,968	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	77,905	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)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,246.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	671,930	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 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	224,691	2,054,742	0.109352	671,930	73,477	90.00
91.00	Nursing School cost	0	2,054,742	0.000000	671,930	0	91.00
92.00	Allied health cost	0	2,054,742	0.000000	671,930	0	92.00
93.00	All other Medical Education	0	2,054,742	0.000000	671,930	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | 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)	633	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	609	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)	402	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	45	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)	-21	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	13	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	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	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,054,742	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	77,905	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,976,837	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)	1,976,837	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)	3,246.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	42,199	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)	42,199	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | 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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	42,199	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,246.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	671,930	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | 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	224,691	2,054,742	0.109352	671,930	73,477	90.00
91.00	Nursing School cost	0	2,054,742	0.000000	671,930	0	91.00
92.00	Allied health cost	0	2,054,742	0.000000	671,930	0	92.00
93.00	All other Medical Education	0	2,054,742	0.000000	671,930	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/12/2018 4:03 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		240,532		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.603346	54,745	33,030	50.00
53.00	05300	ANESTHESIOLOGY	0.381099	29,886	11,390	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256188	123,563	31,655	54.00
60.00	06000	LABORATORY	0.307282	120,639	37,070	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.263975	905	239	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.147574	6,739	995	64.00
65.00	06500	RESPIRATORY THERAPY	0.931722	81,867	76,277	65.00
66.00	06600	PHYSICAL THERAPY	0.293974	9,750	2,866	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300263	13,115	3,938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.645850	69,518	44,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.949086	10,527	9,991	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.828109	97,945	81,109	73.00
76.00	03950	CARDIAC REHAB	0.731045	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.270215	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.844149	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.707354	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		619,199	333,458	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)		619,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/12/2018 4:03 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	0.603346	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.381099	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256188	3,273	839	54.00
60.00	06000	LABORATORY	0.307282	3,222	990	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.263975	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.147574	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.931722	8,113	7,559	65.00
66.00	06600	PHYSICAL THERAPY	0.293974	3,302	971	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300263	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.645850	4,915	3,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.949086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.828109	3,774	3,125	73.00
76.00	03950	CARDIAC REHAB	0.731045	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.270215	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.844149	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.707354	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,599	16,658	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)		26,599		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/12/2018 4:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,696,179	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)	3,696,179	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)	3,733,141	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)	15,301	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,264,060	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)	2,453,780	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)	2,453,780	30.00
31.00	Primary payer payments	1,576	31.00
32.00	Subtotal (line 30 minus line 31)	2,452,204	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	265,760	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	172,744	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	200,427	36.00
37.00	Subtotal (see instructions)	2,624,948	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)	2,624,948	40.00
40.01	Sequestration adjustment (see instructions)	52,499	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,264,556	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	307,893	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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 9/12/2018 4:03 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		760,433		2,067,348	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	11/30/2017	35,950	11/30/2017	43,595	3.01
3.02		04/12/2018	22,622	04/12/2018	153,613	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)		58,572		197,208	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)		819,005		2,264,556	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		173,564		307,893	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		992,569		2,572,449	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/12/2018 4:03 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		85,304		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	11/30/2017	1,092		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)		1,092		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)		86,396		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		6,053		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		92,449		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/12/2018 4:03 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: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-2 | Date/Time Prepared: 9/12/2018 4:03 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)	78,684	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)	16,825	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	24	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)	95,509	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	95,509	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)	95,509	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,173	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)	94,336	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)	94,336	0	19.00
19.01	Sequestration adjustment (see instructions)	1,887	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	86,396	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)	6,053	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: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part V Date/Time Prepared: 9/12/2018 4:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,070,309	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,070,309	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,081,012	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,081,012	19.00
20.00	Deductibles (exclude professional component)	86,116	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	994,896	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	994,896	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,584	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,930	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,522	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,012,826	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,012,826	30.00
30.01	Sequestration adjustment (see instructions)	20,257	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	819,005	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)	173,564	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-3 Part VII Date/Time Prepared: 9/12/2018 4:03 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	42,199		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	42,199	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	42,199	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	42,199	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	42,199	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	42,199	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	42,199	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	42,199	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	42,199	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	42,199	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	42,199	0	40.00
41.00	Interim payments	42,199	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G | Date/Time Prepared: 9/12/2018 4:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,746,592	0	0	0	1.00
2.00	Temporary investments	6,124,090	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,213,939	0	0	0	4.00
5.00	Other receivable	356,711	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,008,093	0	0	0	6.00
7.00	Inventory	327,290	0	0	0	7.00
8.00	Prepaid expenses	181,676	0	0	0	8.00
9.00	Other current assets	256,744	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)	12,198,949	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	422,167	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,044,104	0	0	0	15.00
16.00	Accumulated depreciation	-8,398,815	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	128,511	0	0	0	19.00
20.00	Accumulated depreciation	-79,427	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	5,460,192	0	0	0	23.00
24.00	Accumulated depreciation	-3,888,885	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,041,254	0	0	0	27.00
28.00	Accumulated depreciation	-1,034,460	0	0	0	28.00
29.00	Minor equipment-nondepreciable	92,017	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,786,658	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,801,434	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	904,734	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,706,168	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,691,775	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	624,870	0	0	0	37.00
38.00	Salaries, wages, and fees payable	832,587	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	70,815	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	25,301	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,553,573	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	630,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,339,656	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,969,656	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,523,229	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,168,546				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)	15,168,546	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,691,775	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-1 | Date/Time Prepared: 9/12/2018 4:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,160,465		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,981,543				2.00
3.00	Total (sum of line 1 and line 2)		15,142,008		0		3.00
4.00	CAPITAL GRANTS AND GIFTS	26,765		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)		26,765		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,168,773		0		11.00
12.00	UNREALIZED LOSSES	227		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)		227		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,168,546		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	CAPITAL GRANTS AND GIFTS		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	UNREALIZED LOSSES		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: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/12/2018 4:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	454,521		454,521	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	19,343		19,343	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	473,864		473,864	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)	473,864		473,864	17.00
18.00	Ancillary services	2,363,366	21,291,511	23,654,877	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,093,869	3,093,869	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	61,020	211,615	272,635	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,898,250	24,596,995	27,495,245	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,140,519		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,140,519		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1303	Period: From 05/01/2017 To 04/30/2018	Worksheet G-3 Date/Time Prepared: 9/12/2018 4:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,495,245	1.00
2.00	Less contractual allowances and discounts on patients' accounts	10,449,552	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,045,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,140,519	4.00
5.00	Net income from service to patients (line 3 minus line 4)	905,174	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	62,560	6.00
7.00	Income from investments	51,139	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	31,260	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	2	16.00
17.00	Revenue from sale of drugs to other than patients	4,984	17.00
18.00	Revenue from sale of medical records and abstracts	8,223	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	1,310	21.00
22.00	Rental of hospital space	33,435	22.00
23.00	Governmental appropriations	249,521	23.00
24.00	OTHER DIETARY REVENUE	11,375	24.00
24.01	SALE: MINOR EQUIPMENT/SUPPLIES	0	24.01
24.02	FITNESS CENTER	6,105	24.02
24.03	PHARM 340B RETAIL/CONTRACT REV	555,842	24.03
24.04	MISC OTHER	10,314	24.04
24.05	CRNA PASS THROUGH AND OTHER	0	24.05
24.06	MEDICAID EHR	51,000	24.06
24.07	MEDICARE EHR	0	24.07
25.00	Total other income (sum of lines 6-24)	1,077,070	25.00
26.00	Total (line 5 plus line 25)	1,982,244	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	LOSS ON DISPOSAL OF ASSET	701	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	701	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,981,543	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-1 | Date/Time Prepared: 9/12/2018 4:03 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	828,776	0	828,776	63,075	891,851	1.00
2.00	Physician Assistant	0	0	0	61,949	61,949	2.00
3.00	Nurse Practitioner	319,595	0	319,595	0	319,595	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	204,245	0	204,245	-7,526	196,719	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	359,640	91,670	451,310	0	451,310	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,712,256	91,670	1,803,926	117,498	1,921,424	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	51,732	51,732	0	51,732	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	51,732	51,732	0	51,732	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,712,256	143,402	1,855,658	117,498	1,973,156	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	18,686	18,686	0	18,686	29.00
30.00	Administrative Costs	99,675	138,097	237,772	-34,132	203,640	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	99,675	156,783	256,458	-34,132	222,326	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,811,931	300,185	2,112,116	83,366	2,195,482	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-1

Component CCN: 14-3404 | Date/Time Prepared: 9/12/2018 4:03 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	891,851		1.00
2.00	Physician Assistant	0	61,949		2.00
3.00	Nurse Practitioner	0	319,595		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	196,719		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	451,310		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,921,424		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	51,732		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	51,732		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,973,156		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	18,686		29.00
30.00	Administrative Costs	-51,680	151,960		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-51,680	170,646		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-51,680	2,143,802		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-2 | Date/Time Prepared: 9/12/2018 4:03 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.90	9,984	4,200	7,980		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.06	5,519	2,100	4,326		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.96	15,503		12,306	15,503	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	428			428	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)	3.96	15,931			15,931	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)					1,973,156	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)					1,973,156	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)					170,646	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,456,041	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,626,687	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,626,687	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,626,687	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,599,843	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2017 To 04/30/2018	Worksheet M-3 Date/Time Prepared: 9/12/2018 4:03 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)			3,599,843	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			40,207	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,559,636	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,931	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)			15,931	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223.44	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)	223.44	223.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,639		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,259,978		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	127		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	28,377		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	28,377		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,288,355		16.00
16.01	Total program charges (see instructions)(from contractor's records)		990,748		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,640		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,939		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.)		934,945		16.04
16.05	Total program cost (see instructions)	0	957,884		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		96,735		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		175,274		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		957,884		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,948		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		973,832		22.00
23.00	Allowable bad debts (see instructions)		72,007		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		46,805		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		58,495		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,020,637		26.00
26.01	Sequestration adjustment (see instructions)		20,413		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		988,998		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)		11,226		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: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-4 | Date/Time Prepared: 9/12/2018 4:03 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)	1,921,424	1,921,424	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000350	0.002772	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	672	5,326	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,597	9,443	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,269	14,769	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,973,156	1,973,156	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,626,687	1,626,687	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003684	0.007485	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,993	12,176	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	13,262	26,945	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	45	356	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	294.71	75.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	31	90	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,136	6,812	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)		40,207	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)		15,948	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2017 To 04/30/2018	Worksheet M-5 Date/Time Prepared: 9/12/2018 4:03 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		899,928	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		04/12/2018	42,869	3.01
3.02		11/30/2017	46,201	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)		89,070	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		988,998	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		11,226	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,000,224	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00