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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/29/2018 8:55 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2018 Time: 8:55 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-176,660	-666,669	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	-179,062	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		444,155		0	10.00
200.00	Total	0	-355,722	-222,514	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 3:03 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 3:03 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 3:03 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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	191,010	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.	Y	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 3:03 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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2018 3:03 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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/30/2018	Y	10/30/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2018 3:03 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	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	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.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 3:03 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.	CHIEF FINANCIAL OFFICER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2018 3:03 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	18	6,570	32,832.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		18	6,570	32,832.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	32,832.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2018 3:03 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)	697	251	1,319			1.00
2.00	HMO and other (see instructions)	96	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	683	0	789			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,380	251	2,128			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		135	238			13.00
14.00	Total (see instructions)	1,380	386	2,366	0.00	137.26	14.00
15.00	CAH visits	10,125	5,100	25,424			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	6,155	0	30,645	0.00	54.90	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	192.16	27.00
28.00	Observation Bed Days		64	226			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	28	49			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: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2018 3:03 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	227	107	502	1.00
2.00	HMO and other (see instructions)			34	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	227	107	502	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/28/2018 3:03 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street					1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County			IL		2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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.	Y 6	13.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2017 To 06/30/2018	Worksheet S-8 Date/Time Prepared: 11/28/2018 3:03 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/28/2018 3:03 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)	0.554122	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,297,441	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,400,259	5.00
6.00	Medicaid charges	11,884,263	6.00
7.00	Medicaid cost (line 1 times line 6)	6,585,332	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)	2,887,632	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	55,315	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,887,632	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)	69,716	101,358	171,074	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	38,631	101,358	139,989	21.00
22.00	Payments received from patients for amounts previously written off as charity care	609	4,611	5,220	22.00
23.00	Cost of charity care (line 21 minus line 22)	38,022	96,747	134,769	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)	809,826	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	101,130	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	155,586	27.01
28.00	Non-Medicare bad debt expense (see instructions)	654,240	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	416,985	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	551,754	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,439,386	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 3:03 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	NEW CAP REL COSTS-BLDG & FIXT		1,443,324	1,443,324	-1,426,624	16,700	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	1,909,206	1,909,206	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	410,590	410,590	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		834,366	834,366	-58,413	775,953	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	85,250	85,250	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	143,820	2,556,445	2,700,265	0	2,700,265	4.00
5.01	00550	ADMINISTRATION & GENERAL	1,865,705	2,243,852	4,109,557	5,586	4,115,143	5.01
7.00	00700	OPERATION OF PLANT	198,383	455,895	654,278	0	654,278	7.00
7.01	00701	OPERATION OF PLANT MOB	0	46,405	46,405	0	46,405	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,227	70,227	0	70,227	8.00
9.00	00900	HOUSEKEEPING	152,619	47,107	199,726	0	199,726	9.00
10.00	01000	DIETARY	177,689	156,421	334,110	-124,149	209,961	10.00
11.00	01100	CAFETERIA	0	0	0	124,149	124,149	11.00
13.00	01300	NURSING ADMINISTRATION	199,111	78,102	277,213	-48,040	229,173	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,974	55,190	165,164	0	165,164	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	48,040	48,040	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	456,825	32,245	489,070	0	489,070	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,103,153	444,967	1,548,120	204,840	1,752,960	30.00
43.00	04300	NURSERY	0	0	0	222,767	222,767	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	384,011	114,367	498,378	0	498,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	350,928	135,045	485,973	-427,607	58,366	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,985	470,621	1,006,606	0	1,006,606	54.00
56.00	05600	RADIOISOTOPE	0	83,141	83,141	0	83,141	56.00
60.00	06000	LABORATORY	673,188	699,089	1,372,277	0	1,372,277	60.00
60.02	06002	GEO PSYCH	166,199	54,125	220,324	0	220,324	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,414	45,414	0	45,414	62.00
65.00	06500	RESPIRATORY THERAPY	234,352	64,770	299,122	-38,148	260,974	65.00
66.00	06600	PHYSICAL THERAPY	0	118,276	118,276	0	118,276	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,748	14,748	38,148	52,896	69.00
69.01	06901	PULMONARY REHAB	66,500	7,209	73,709	0	73,709	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,873	436,323	474,196	-145,051	329,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	145,051	145,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,111	1,147,867	1,358,978	0	1,358,978	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,363,518	1,559,562	5,923,080	-105,308	5,817,772	88.00
90.00	09000	CLINIC	31,552	524,567	556,119	0	556,119	90.00
91.00	09100	EMERGENCY	438,211	1,833,683	2,271,894	0	2,271,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	86,131	11,113	97,244	0	97,244	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		989,138	989,138	-989,138	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,986,838	16,773,604	28,760,442	-168,851	28,591,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,635	31,668	72,303	168,851	241,154	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	12,027,473	16,805,272	28,832,745	0	28,832,745	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	16,700		1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-14,753	1,894,453		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-44,282	366,308		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-40,412	735,541		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	85,250		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,700,265		4.00
5.01	00550	ADMINISTRATION & GENERAL	-600,453	3,514,690		5.01
7.00	00700	OPERATION OF PLANT	0	654,278		7.00
7.01	00701	OPERATION OF PLANT MOB	0	46,405		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,227		8.00
9.00	00900	HOUSEKEEPING	0	199,726		9.00
10.00	01000	DIETARY	-906	209,055		10.00
11.00	01100	CAFETERIA	-35,450	88,699		11.00
13.00	01300	NURSING ADMINISTRATION	0	229,173		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,844	162,320		16.00
17.00	01700	SOCIAL SERVICE	0	48,040		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	489,070		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,752,960		30.00
43.00	04300	NURSERY	0	222,767		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	498,378		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,366		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,006,606		54.00
56.00	05600	RADIOISOTOPE	0	83,141		56.00
60.00	06000	LABORATORY	0	1,372,277		60.00
60.02	06002	GEO PSYCH	-41,002	179,322		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,414		62.00
65.00	06500	RESPIRATORY THERAPY	0	260,974		65.00
66.00	06600	PHYSICAL THERAPY	-8,126	110,150		66.00
69.00	06900	ELECTROCARDIOLOGY	0	52,896		69.00
69.01	06901	PULMONARY REHAB	0	73,709		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	329,145		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	145,051		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-406,791	952,187		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-29,715	5,788,057		88.00
90.00	09000	CLINIC	-522,954	33,165		90.00
91.00	09100	EMERGENCY	-430,781	1,841,113		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	97,244		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,178,469	26,413,122		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	241,154		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,178,469	26,654,276		200.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 3:03 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,074,031		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	300,152		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	49,243		3.00
	TOTALS		0	1,423,426		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	66,026	58,123		1.00
	TOTALS		66,026	58,123		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	14,300		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	14,300		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	48,040	0		1.00
	TOTALS		48,040	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	37,939		1.00
2.00	ADMINISTRATION & GENERAL	5.01	0	5,586		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	835,175		3.00
4.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	110,438		4.00
	TOTALS		0	989,138		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	152,294	52,546		1.00
2.00	NURSERY	43.00	165,622	57,145		2.00
	TOTALS		317,916	109,691		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	85,250		1.00
	TOTALS		0	85,250		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	41,265	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	3,117		2.00
	TOTALS		41,265	3,117		
	I - TO RECLASS NON RHC TIME					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	168,851	0		1.00
	TOTALS		168,851	0		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	145,051		1.00
	TOTALS		0	145,051		
500.00	Grand Total: Increases		642,098	2,828,096		500.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 3:03 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,423,426	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,423,426			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	66,026	58,123	0		1.00
	TOTALS		66,026	58,123			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,198	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,102	11		2.00
	TOTALS		0	14,300			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	NURSING ADMINISTRATION	13.00	48,040	0	0		1.00
	TOTALS		48,040	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	989,138	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	11		4.00
	TOTALS		0	989,138			
	F - TO RECLASS ACUTE AND NURSERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	152,294	52,546	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	165,622	57,145	0		2.00
	TOTALS		317,916	109,691			
	G - MOB EQUIPMENT DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	85,250	9		1.00
	TOTALS		0	85,250			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	41,265	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	3,117	0		2.00
	TOTALS		41,265	3,117			
	I - TO RECLASS NON RHC TIME						
1.00	RURAL HEALTH CLINIC	88.00	168,851	0	0		1.00
	TOTALS		168,851	0			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	145,051	0		1.00
	TOTALS		0	145,051			
500.00	Grand Total: Decreases		642,098	2,828,096			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	499,957	0	0	0	0	1.00
2.00	Land Improvements	1,326,180	10,352	0	10,352	0	2.00
3.00	Buildings and Fixtures	24,896,621	59,377	0	59,377	14,996	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,510,685	1,931,420	0	1,931,420	413,972	6.00
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,202,212	2,001,149	0	2,001,149	428,968	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,202,212	2,001,149	0	2,001,149	428,968	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	499,957	0	1.00
2.00	Land Improvements	1,336,532	0	2.00
3.00	Buildings and Fixtures	24,941,002	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,028,133	0	6.00
7.00	HIT designated Assets	1,968,769	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,774,393	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,774,393	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2018 3:03 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	NEW CAP REL COSTS-BLDG & FIXT	1,443,324	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	834,366	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,277,690	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,443,324		1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0		1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	834,366		2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	0	2,277,690		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III | Date/Time Prepared: 11/28/2018 3:03 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,595,503	0	1,595,503	0.043386	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	20,110,942	0	20,110,942	0.546874	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,071,046	0	5,071,046	0.137896	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9,501,960	0	9,501,960	0.258385	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	494,942	0	494,942	0.013459	0	2.01
3.00	Total (sum of lines 1-2)	36,774,393	0	36,774,393	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	16,700	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,069,977	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	300,152	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	708,704	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	85,250	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,180,783	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	16,700	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	824,476	0	0	0	1,894,453	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	66,156	0	0	0	366,308	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,837	0	0	0	735,541	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	85,250	2.01
3.00	Total (sum of lines 1-2)	917,469	0	0	0	3,098,252	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 3:03 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-4,054	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,484	ADMINISTRATION & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-994,737			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,450	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,844	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	-906	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	-8,126	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 3:03 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	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-40,412	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00	LOBBYING	A	-9,154	ADMINISTRATION & GENERAL	5.01	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-89,231	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTISING- RHC	A	-22,628	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-14,940	ADMINISTRATION & GENERAL	5.01	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-10,699	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	RHC SALARY REIMBURSEMENT	B	-7,087	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.02
45.03	PROVIDER TAX	A	-390,468	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-1,953	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-44,282	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-3,385	ADMINISTRATION & GENERAL	5.01	0	45.08
45.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.09
45.10	MARKETING SALARIES	A	-69,605	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-17,972	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTHAGE INTEREST	A	-2,261	ADMINISTRATION & GENERAL	5.01	0	45.12
45.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.13
45.14	340B PHARMACY	A	-406,791	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
45.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.15
45.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,178,469				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 3:03 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2018 3:03 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	52,762	0	52,762	0	0	1.00
2.00	60.02	GEO PSYCH	41,002	41,002	0	0	0	2.00
3.00	90.00	CLINIC	522,954	522,954	0	0	0	3.00
4.00	91.00	EMERGENCY	1,786,730	430,781	1,355,949	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,403,448	994,737	1,408,711		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	60.02	GEO PSYCH	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	60.02	GEO PSYCH	0	0	0	41,002		2.00
3.00	90.00	CLINIC	0	0	0	522,954		3.00
4.00	91.00	EMERGENCY	0	0	0	430,781		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	994,737		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2018 3:03 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)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	559.75	408.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.44	61.08	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.72	40.72	30.54			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)					45,586	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					24,966	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					70,552	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					70,552	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)					70,552	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2018 3:03 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)	81.44	61.08	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	70,552		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	70,552		63.00
64.00	Total cost of outside supplier services (from your records)	78,678		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	8,126		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2018 3:03 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.40	7.00
8.00	Optional travel expense rate per mile		0.55	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	210.50	179.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.18	57.89	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.59	38.59	28.95			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)	16,246	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	10,362	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	26,608	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	26,608	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)	68.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	53,282	22.00
23.00	Total salary equivalency (see instructions)	53,282	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2018 3:03 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.18	57.89	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		53,282	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		53,282	63.00
64.00	Total cost of outside supplier services (from your records)		31,788	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2018 3:03 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	82.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.17	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.09	37.09	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	1,080	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)					6,082	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					6,082	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					6,082	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)					74.17	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,853	22.00
23.00	Total salary equivalency (see instructions)					57,853	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					594	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2018 3:03 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.17	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	57,853	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	57,853	63.00
64.00	Total cost of outside supplier services (from your records)	7,578	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	16,700	16,700				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,894,453	0	1,894,453			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	366,308	0	0	366,308		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	735,541				735,541	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	85,250				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,700,265	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	3,514,690	5,878	455,031	145,864	190,156	5.01
7.00	00700	OPERATION OF PLANT	654,278	730	93,892	0	35,752	7.00
7.01	00701	OPERATION OF PLANT MOB	46,405	0	0	7,487	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	70,227	0	8,130	0	2,639	8.00
9.00	00900	HOUSEKEEPING	199,726	0	20,369	2,945	6,611	9.00
10.00	01000	DIETARY	209,055	0	38,504	0	12,497	10.00
11.00	01100	CAFETERIA	88,699	0	21,932	0	7,119	11.00
13.00	01300	NURSING ADMINISTRATION	229,173	0	11,837	0	3,842	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	162,320	1,800	35,154	0	24,415	16.00
17.00	01700	SOCIAL SERVICE	48,040	0	7,817	0	2,537	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	489,070	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,752,960	0	436,941	0	141,819	30.00
43.00	04300	NURSERY	222,767	0	10,050	0	3,262	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	498,378	0	178,984	0	58,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,366	0	39,576	0	12,845	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,006,606	0	197,834	0	64,212	54.00
56.00	05600	RADIOISOTOPE	83,141	0	13,847	0	4,494	56.00
60.00	06000	LABORATORY	1,372,277	0	75,399	0	24,473	60.00
60.02	06002	GEO PSYCH	179,322	0	0	14,242	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,414	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	260,974	0	30,865	0	10,018	65.00
66.00	06600	PHYSICAL THERAPY	110,150	0	11,569	0	3,755	66.00
69.00	06900	ELECTROCARDIOLOGY	52,896	0	50,251	0	16,310	69.00
69.01	06901	PULMONARY REHAB	73,709	0	0	14,081	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	329,145	0	14,562	0	4,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,051	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	952,187	0	55,879	0	18,137	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,788,057	8,292	0	112,896	59,906	88.00
90.00	09000	CLINIC	33,165	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,841,113	0	82,725	0	26,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	97,244	0	0	9,612	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,413,122	16,700	1,891,148	307,127	734,468	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,305	0	1,073	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241,154	0	0	59,181	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,654,276	16,700	1,894,453	366,308	735,541	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	4.00	4A	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	85,250					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,700,265				4.00
5.01	00550	ADMINISTRATION & GENERAL	33,946	423,935	4,769,500	4,769,500		5.01
7.00	00700	OPERATION OF PLANT	0	45,078	829,730	180,829	1,010,559	7.00
7.01	00701	OPERATION OF PLANT MOB	1,743	0	55,635	12,125	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	80,996	17,652	6,106	8.00
9.00	00900	HOUSEKEEPING	685	34,679	265,015	57,757	15,298	9.00
10.00	01000	DIETARY	0	25,373	285,429	62,206	28,918	10.00
11.00	01100	CAFETERIA	0	15,003	132,753	28,932	16,472	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,327	279,179	60,843	8,890	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,989	248,678	54,196	26,402	16.00
17.00	01700	SOCIAL SERVICE	0	10,916	69,310	15,105	5,871	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	103,802	592,872	129,209	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	285,269	2,616,989	570,339	328,164	30.00
43.00	04300	NURSERY	0	37,633	273,712	59,652	7,548	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,257	822,712	179,299	134,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,501	118,288	25,779	29,723	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,789	1,390,441	303,029	148,583	54.00
56.00	05600	RADIOISOTOPE	0	0	101,482	22,117	10,400	56.00
60.00	06000	LABORATORY	0	152,965	1,625,114	354,172	56,629	60.00
60.02	06002	GEO PSYCH	3,315	37,765	234,644	51,138	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	45,414	9,897	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	43,874	345,731	75,348	23,181	65.00
66.00	06600	PHYSICAL THERAPY	0	0	125,474	27,345	8,689	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,376	128,833	28,077	37,741	69.00
69.01	06901	PULMONARY REHAB	3,277	15,110	106,177	23,140	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,606	357,039	77,812	10,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	145,051	31,612	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,970	1,074,173	234,102	41,968	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,274	953,136	6,948,561	1,514,345	0	88.00
90.00	09000	CLINIC	0	7,169	40,334	8,790	0	90.00
91.00	09100	EMERGENCY	0	99,572	2,050,260	446,828	62,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,237	19,571	128,664	28,041	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,477	2,652,665	26,288,190	4,689,716	1,008,076	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,378	954	2,483	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,773	47,600	361,708	78,830	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,250	2,700,265	26,654,276	4,769,500	1,010,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	67,760					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	104,754				8.00
9.00	00900	HOUSEKEEPING	937	0	339,007			9.00
10.00	01000	DIETARY	0	0	5,982	382,535		10.00
11.00	01100	CAFETERIA	0	0	3,408	0	181,565	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,839	0	4,720	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	11,687	0	5,673	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,215	0	1,041	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,671	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	36,086	67,889	382,535	34,065	30.00
43.00	04300	NURSERY	0	0	1,562	0	4,868	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	38,859	27,809	0	12,011	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,149	0	969	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,606	30,738	0	15,544	54.00
56.00	05600	RADIOISOTOPE	0	0	2,151	0	0	56.00
60.00	06000	LABORATORY	0	0	11,715	0	22,574	60.00
60.02	06002	GEO PSYCH	4,532	0	6,746	0	6,625	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,796	0	6,055	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,798	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,808	0	1,294	69.00
69.01	06901	PULMONARY REHAB	4,480	0	6,670	0	3,073	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,262	0	1,448	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	8,682	0	4,195	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35,922	3,027	82,150	0	41,845	88.00
90.00	09000	CLINIC	0	1,296	0	0	0	90.00
91.00	09100	EMERGENCY	0	13,880	12,853	0	11,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3,058	0	4,553	0	2,540	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,929	104,754	310,462	382,535	181,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	514	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,831	0	28,031	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,760	104,754	339,007	382,535	181,565	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	355,471					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	346,636				16.00
17.00	01700	SOCIAL SERVICE	0	0	92,542			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,518	0	0	731,270		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153,238	23,897	90,691	0	4,303,893	30.00
43.00	04300	NURSERY	21,897	1,340	0	0	370,579	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,032	19,340	0	0	1,288,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,361	1,453	0	0	186,722	52.00
53.00	05300	ANESTHESIOLOGY	0	11,568	0	731,270	742,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,332	0	0	1,980,273	54.00
56.00	05600	RADIOISOTOPE	0	3,169	0	0	139,319	56.00
60.00	06000	LABORATORY	0	80,734	0	0	2,150,938	60.00
60.02	06002	GEO PSYCH	0	3,634	0	0	307,319	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	571	0	0	55,882	62.00
65.00	06500	RESPIRATORY THERAPY	27,238	6,968	0	0	489,317	65.00
66.00	06600	PHYSICAL THERAPY	0	1,861	0	0	165,167	66.00
69.00	06900	ELECTROCARDIOLOGY	5,820	5,210	0	0	214,783	69.00
69.01	06901	PULMONARY REHAB	0	954	0	0	144,494	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,188	0	0	454,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,932	0	0	178,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,870	19,837	0	0	1,401,827	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	57,513	0	0	8,683,363	88.00
90.00	09000	CLINIC	0	732	0	0	51,152	90.00
91.00	09100	EMERGENCY	51,073	20,190	1,851	0	2,670,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	11,424	213	0	0	178,493	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,471	346,636	92,542	731,270	26,158,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,329	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	487,400	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	355,471	346,636	92,542	731,270	26,654,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,303,893		30.00
43.00	04300	NURSERY	0	370,579		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,288,488		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	186,722		52.00
53.00	05300	ANESTHESIOLOGY	0	742,838		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,980,273		54.00
56.00	05600	RADIOISOTOPE	0	139,319		56.00
60.00	06000	LABORATORY	0	2,150,938		60.00
60.02	06002	GEO PSYCH	0	307,319		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	55,882		62.00
65.00	06500	RESPIRATORY THERAPY	0	489,317		65.00
66.00	06600	PHYSICAL THERAPY	0	165,167		66.00
69.00	06900	ELECTROCARDIOLOGY	0	214,783		69.00
69.01	06901	PULMONARY REHAB	0	144,494		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	454,686		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	178,595		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,401,827		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	8,683,363		88.00
90.00	09000	CLINIC	0	51,152		90.00
91.00	09100	EMERGENCY	0	2,670,419		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	178,493		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,158,547		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,329		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	487,400		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	26,654,276		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	5,878	455,031	145,864	190,156	5.01
7.00	00700	OPERATION OF PLANT	0	730	93,892	0	35,752	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,487	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8,130	0	2,639	8.00
9.00	00900	HOUSEKEEPING	0	0	20,369	2,945	6,611	9.00
10.00	01000	DIETARY	0	0	38,504	0	12,497	10.00
11.00	01100	CAFETERIA	0	0	21,932	0	7,119	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	11,837	0	3,842	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,800	35,154	0	24,415	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,817	0	2,537	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	436,941	0	141,819	30.00
43.00	04300	NURSERY	0	0	10,050	0	3,262	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	178,984	0	58,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	39,576	0	12,845	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	197,834	0	64,212	54.00
56.00	05600	RADIOISOTOPE	0	0	13,847	0	4,494	56.00
60.00	06000	LABORATORY	0	0	75,399	0	24,473	60.00
60.02	06002	GEO PSYCH	0	0	0	14,242	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	30,865	0	10,018	65.00
66.00	06600	PHYSICAL THERAPY	0	0	11,569	0	3,755	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	50,251	0	16,310	69.00
69.01	06901	PULMONARY REHAB	0	0	0	14,081	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	14,562	0	4,726	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	55,879	0	18,137	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,292	0	112,896	59,906	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	82,725	0	26,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	9,612	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,700	1,891,148	307,127	734,468	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,305	0	1,073	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	59,181	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,700	1,894,453	366,308	735,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	2A	4.00	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	33,946	830,875	0	830,875		5.01
7.00	00700	OPERATION OF PLANT	0	130,374	0	31,502	161,876	7.00
7.01	00701	OPERATION OF PLANT MOB	1,743	9,230	0	2,112	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,769	0	3,075	978	8.00
9.00	00900	HOUSEKEEPING	685	30,610	0	10,062	2,450	9.00
10.00	01000	DIETARY	0	51,001	0	10,837	4,632	10.00
11.00	01100	CAFETERIA	0	29,051	0	5,040	2,639	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,679	0	10,599	1,424	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,369	0	9,441	4,229	16.00
17.00	01700	SOCIAL SERVICE	0	10,354	0	2,631	940	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	22,509	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	578,760	0	99,357	52,567	30.00
43.00	04300	NURSERY	0	13,312	0	10,392	1,209	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	237,077	0	31,235	21,533	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,421	0	4,491	4,761	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	262,046	0	52,789	23,801	54.00
56.00	05600	RADIOISOTOPE	0	18,341	0	3,853	1,666	56.00
60.00	06000	LABORATORY	0	99,872	0	61,699	9,071	60.00
60.02	06002	GEO PSYCH	3,315	17,557	0	8,908	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,724	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	40,883	0	13,126	3,713	65.00
66.00	06600	PHYSICAL THERAPY	0	15,324	0	4,764	1,392	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,561	0	4,891	6,046	69.00
69.01	06901	PULMONARY REHAB	3,277	17,358	0	4,031	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,288	0	13,555	1,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,507	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,016	0	40,782	6,723	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,274	207,368	0	263,808	0	88.00
90.00	09000	CLINIC	0	0	0	1,531	0	90.00
91.00	09100	EMERGENCY	0	109,575	0	77,840	9,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,237	11,849	0	4,885	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,477	3,020,920	0	816,976	161,478	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,378	0	166	398	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,773	72,954	0	13,733	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,250	3,098,252	0	830,875	161,876	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	11,342					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,822				8.00
9.00	00900	HOUSEKEEPING	157	0	43,279			9.00
10.00	01000	DIETARY	0	0	764	67,234		10.00
11.00	01100	CAFETERIA	0	0	435	0	37,165	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	235	0	966	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,492	0	1,161	16.00
17.00	01700	SOCIAL SERVICE	0	0	155	0	213	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	342	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,106	8,667	67,234	6,973	30.00
43.00	04300	NURSERY	0	0	199	0	996	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,499	3,550	0	2,459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	785	0	198	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,642	3,924	0	3,182	54.00
56.00	05600	RADIOISOTOPE	0	0	275	0	0	56.00
60.00	06000	LABORATORY	0	0	1,496	0	4,621	60.00
60.02	06002	GEO PSYCH	759	0	861	0	1,356	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	612	0	1,239	65.00
66.00	06600	PHYSICAL THERAPY	0	0	229	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	997	0	265	69.00
69.01	06901	PULMONARY REHAB	750	0	851	0	629	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	289	0	296	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	1,108	0	859	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,012	428	10,488	0	8,566	88.00
90.00	09000	CLINIC	0	183	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,964	1,641	0	2,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	512	0	581	0	520	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,190	14,822	39,634	67,234	37,165	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	66	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,152	0	3,579	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,342	14,822	43,279	67,234	37,165	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	28,903					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,692				16.00
17.00	01700	SOCIAL SERVICE	0	0	14,293			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	611	0	0	23,462		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,460	5,357	14,007		850,488	30.00
43.00	04300	NURSERY	1,780	300	0		28,188	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,393	4,335	0		310,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355	326	0		63,337	52.00
53.00	05300	ANESTHESIOLOGY	0	2,593	0		2,593	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,007	0		365,391	54.00
56.00	05600	RADIOISOTOPE	0	710	0		24,845	56.00
60.00	06000	LABORATORY	0	18,087	0		194,846	60.00
60.02	06002	GEO PSYCH	0	815	0		30,256	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	128	0		1,852	62.00
65.00	06500	RESPIRATORY THERAPY	2,215	1,562	0		63,350	65.00
66.00	06600	PHYSICAL THERAPY	0	417	0		22,126	66.00
69.00	06900	ELECTROCARDIOLOGY	473	1,168	0		80,401	69.00
69.01	06901	PULMONARY REHAB	0	214	0		23,833	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,163	0		36,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	433	0		5,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,534	4,447	0		129,469	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,892	0		509,562	88.00
90.00	09000	CLINIC	0	164	0		1,878	90.00
91.00	09100	EMERGENCY	4,153	4,526	286		212,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	929	48	0		19,324	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,903	77,692	14,293	0	2,976,364	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		5,008	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		93,418	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				23,462	23,462	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,903	77,692	14,293	23,462	3,098,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	850,488		30.00
43.00	04300	NURSERY	0	28,188		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	310,081		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	63,337		52.00
53.00	05300	ANESTHESIOLOGY	0	2,593		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	365,391		54.00
56.00	05600	RADIOISOTOPE	0	24,845		56.00
60.00	06000	LABORATORY	0	194,846		60.00
60.02	06002	GEO PSYCH	0	30,256		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,852		62.00
65.00	06500	RESPIRATORY THERAPY	0	63,350		65.00
66.00	06600	PHYSICAL THERAPY	0	22,126		66.00
69.00	06900	ELECTROCARDIOLOGY	0	80,401		69.00
69.01	06901	PULMONARY REHAB	0	23,833		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,343		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,940		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	129,469		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	509,562		88.00
90.00	09000	CLINIC	0	1,878		90.00
91.00	09100	EMERGENCY	0	212,261		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	19,324		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,976,364		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,008		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	93,418		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	23,462		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,098,252		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADMIN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	42,412				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				50,734		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	10,187	9,955	13,116	9,955	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,132	0	7,705	4,132	7,705	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,322	42,338	20,961	50,660	20,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,700	1,894,453	366,308	735,541	85,250	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.006729	44.667853	14.652320	14.497990	3.410000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,883,653					4.00
5.01	00550	ADMINISTRATION & GENERAL	1,865,705	-4,769,500	21,884,776			5.01
7.00	00700	OPERATION OF PLANT	198,383	0	829,730	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	55,635	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	80,996	182	0	8.00
9.00	00900	HOUSEKEEPING	152,619	0	265,015	456	201	9.00
10.00	01000	DIETARY	111,663	0	285,429	862	0	10.00
11.00	01100	CAFETERIA	66,026	0	132,753	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	151,071	0	279,179	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,974	0	248,678	787	0	16.00
17.00	01700	SOCIAL SERVICE	48,040	0	69,310	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	456,825	0	592,872	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,255,447	0	2,616,989	9,782	0	30.00
43.00	04300	NURSERY	165,622	0	273,712	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	384,011	0	822,712	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,012	0	118,288	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,985	0	1,390,441	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	101,482	310	0	56.00
60.00	06000	LABORATORY	673,188	0	1,625,114	1,688	0	60.00
60.02	06002	GEO PSYCH	166,199	0	234,644	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	45,414	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	193,087	0	345,731	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	125,474	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	41,265	0	128,833	1,125	0	69.00
69.01	06901	PULMONARY REHAB	66,500	0	106,177	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,873	0	357,039	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	145,051	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,111	0	1,074,173	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,194,667	0	6,948,561	0	7,705	88.00
90.00	09000	CLINIC	31,552	0	40,334	0	0	90.00
91.00	09100	EMERGENCY	438,211	0	2,050,260	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	86,131	0	128,664	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,674,167	-4,769,500	21,518,690	30,049	10,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,378	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209,486	0	361,708	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,700,265		4,769,500	1,010,559	67,760	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.227225		0.217937	33.547754	4.662171	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		830,875	161,876	11,342	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.037966	5.373834	0.780377	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	46,400					8.00
9.00	00900	HOUSEKEEPING	0	48,847				9.00
10.00	01000	DIETARY	0	862	2,166			10.00
11.00	01100	CAFETERIA	0	491	0	226,635		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	5,892	98,637	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	7,081	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	1,300	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,086	2,086	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,984	9,782	2,166	42,521	42,521	30.00
43.00	04300	NURSERY	0	225	0	6,076	6,076	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,212	4,007	0	14,993	14,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	1,210	1,210	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,141	4,429	0	19,402	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	28,178	0	60.00
60.02	06002	GEO PSYCH	0	972	0	8,269	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	7,558	7,558	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,615	1,615	69.00
69.01	06901	PULMONARY REHAB	0	961	0	3,836	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	1,807	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	5,236	5,236	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,341	11,837	0	52,233	0	88.00
90.00	09000	CLINIC	574	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,148	1,852	0	14,172	14,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	656	0	3,170	3,170	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,400	44,734	2,166	226,635	98,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,039	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	104,754	339,007	382,535	181,565	355,471	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.257629	6.940181	176.608957	0.801134	3.603830	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,822	43,279	67,234	37,165	28,903	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.319440	0.886011	31.040628	0.163986	0.293024	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 3:03 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,207,198				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,254,345	98	0		30.00
43.00	04300	NURSERY	182,485	0	0		43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,633,762	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	197,913	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,575,343	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,939,875	0	0		54.00
56.00	05600	RADIOISOTOPE	431,538	0	0		56.00
60.00	06000	LABORATORY	10,995,607	0	0		60.00
60.02	06002	GEO PSYCH	494,957	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,746	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	948,934	0	0		65.00
66.00	06600	PHYSICAL THERAPY	253,456	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	709,498	0	0		69.00
69.01	06901	PULMONARY REHAB	129,949	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	706,491	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	263,101	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,701,420	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	7,832,413	0	0		88.00
90.00	09000	CLINIC	99,723	0	0		90.00
91.00	09100	EMERGENCY	2,749,578	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	29,064	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,207,198	100	2,080		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0	0		194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	346,636	92,542	731,270		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007343	925.420000	351.572115		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,692	14,293	23,462		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001646	142.930000	11.279808		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,303,893		4,303,893	0	0	30.00
43.00	04300	NURSERY	370,579		370,579	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,488		1,288,488	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,722		186,722	0	0	52.00
53.00	05300	ANESTHESIOLOGY	742,838		742,838	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,273		1,980,273	0	0	54.00
56.00	05600	RADIOISOTOPE	139,319		139,319	0	0	56.00
60.00	06000	LABORATORY	2,150,938		2,150,938	0	0	60.00
60.02	06002	GEO PSYCH	307,319		307,319	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,882		55,882	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	489,317	0	489,317	0	0	65.00
66.00	06600	PHYSICAL THERAPY	165,167	0	165,167	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	214,783		214,783	0	0	69.00
69.01	06901	PULMONARY REHAB	144,494		144,494	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,686		454,686	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,595		178,595	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,827		1,401,827	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,683,363		8,683,363	0	0	88.00
90.00	09000	CLINIC	51,152		51,152	0	0	90.00
91.00	09100	EMERGENCY	2,670,419		2,670,419	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,455		416,455		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	178,493		178,493	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,575,002	0	26,575,002	0	0	200.00
201.00		Less Observation Beds	416,455		416,455		0	201.00
202.00		Total (see instructions)	26,158,547	0	26,158,547	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 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	2,556,336		2,556,336			30.00
43.00	04300	NURSERY	182,485		182,485			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	648,292	1,985,470	2,633,762	0.489220	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196,913	1,000	197,913	0.943455	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	252,160	1,323,183	1,575,343	0.471540	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,363	10,320,512	10,939,875	0.181014	0.000000	54.00
56.00	05600	RADIOISOTOPE	19,239	412,299	431,538	0.322843	0.000000	56.00
60.00	06000	LABORATORY	1,012,880	9,982,727	10,995,607	0.195618	0.000000	60.00
60.02	06002	GEO PSYCH	0	494,957	494,957	0.620900	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	40,094	37,652	77,746	0.718777	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	474,885	474,049	948,934	0.515649	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	249,694	3,762	253,456	0.651659	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	53,650	655,848	709,498	0.302725	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	129,949	129,949	1.111929	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,080	347,411	706,491	0.643584	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,000	198,101	263,101	0.678808	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	870,823	1,830,597	2,701,420	0.518922	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,832,413	7,832,413			88.00
90.00	09000	CLINIC	0	99,723	99,723	0.512941	0.000000	90.00
91.00	09100	EMERGENCY	43,689	2,705,889	2,749,578	0.971210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,471	651,538	698,009	0.596633	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	29,064	29,064	6.141378	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,691,054	39,516,144	47,207,198			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,691,054	39,516,144	47,207,198			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 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
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
60.02	06002	GEO PSYCH	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,303,893		4,303,893	0	4,303,893	30.00
43.00	04300	NURSERY	370,579		370,579	0	370,579	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,488		1,288,488	0	1,288,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,722		186,722	0	186,722	52.00
53.00	05300	ANESTHESIOLOGY	742,838		742,838	0	742,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,273		1,980,273	0	1,980,273	54.00
56.00	05600	RADIOISOTOPE	139,319		139,319	0	139,319	56.00
60.00	06000	LABORATORY	2,150,938		2,150,938	0	2,150,938	60.00
60.02	06002	GEO PSYCH	307,319		307,319	0	307,319	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,882		55,882	0	55,882	62.00
65.00	06500	RESPIRATORY THERAPY	489,317	0	489,317	0	489,317	65.00
66.00	06600	PHYSICAL THERAPY	165,167	8,126	173,293	0	173,293	66.00
69.00	06900	ELECTROCARDIOLOGY	214,783		214,783	0	214,783	69.00
69.01	06901	PULMONARY REHAB	144,494		144,494	0	144,494	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,686		454,686	0	454,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,595		178,595	0	178,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,827		1,401,827	0	1,401,827	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,683,363		8,683,363	0	8,683,363	88.00
90.00	09000	CLINIC	51,152		51,152	0	51,152	90.00
91.00	09100	EMERGENCY	2,670,419		2,670,419	0	2,670,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,455		416,455		416,455	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	178,493		178,493	0	178,493	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,575,002	0	26,583,128	0	26,583,128	200.00
201.00		Less Observation Beds	416,455		416,455		416,455	201.00
202.00		Total (see instructions)	26,158,547	0	26,166,673	0	26,166,673	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,556,336		2,556,336			30.00
43.00	04300	NURSERY	182,485		182,485			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	648,292	1,985,470	2,633,762	0.489220	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196,913	1,000	197,913	0.943455	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	252,160	1,323,183	1,575,343	0.471540	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,363	10,320,512	10,939,875	0.181014	0.000000	54.00
56.00	05600	RADIOISOTOPE	19,239	412,299	431,538	0.322843	0.000000	56.00
60.00	06000	LABORATORY	1,012,880	9,982,727	10,995,607	0.195618	0.000000	60.00
60.02	06002	GEO PSYCH	0	494,957	494,957	0.620900	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	40,094	37,652	77,746	0.718777	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	474,885	474,049	948,934	0.515649	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	249,694	3,762	253,456	0.651659	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	53,650	655,848	709,498	0.302725	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	129,949	129,949	1.111929	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,080	347,411	706,491	0.643584	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,000	198,101	263,101	0.678808	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	870,823	1,830,597	2,701,420	0.518922	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,832,413	7,832,413	1.108645	0.000000	88.00
90.00	09000	CLINIC	0	99,723	99,723	0.512941	0.000000	90.00
91.00	09100	EMERGENCY	43,689	2,705,889	2,749,578	0.971210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,471	651,538	698,009	0.596633	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	29,064	29,064	6.141378	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,691,054	39,516,144	47,207,198			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,691,054	39,516,144	47,207,198			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.489220		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.943455		52.00
53.00	05300	ANESTHESIOLOGY	0.471540		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181014		54.00
56.00	05600	RADIOISOTOPE	0.322843		56.00
60.00	06000	LABORATORY	0.195618		60.00
60.02	06002	GEO PSYCH	0.620900		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.718777		62.00
65.00	06500	RESPIRATORY THERAPY	0.515649		65.00
66.00	06600	PHYSICAL THERAPY	0.683720		66.00
69.00	06900	ELECTROCARDIOLOGY	0.302725		69.00
69.01	06901	PULMONARY REHAB	1.111929		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.643584		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678808		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518922		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.108645		88.00
90.00	09000	CLINIC	0.512941		90.00
91.00	09100	EMERGENCY	0.971210		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.596633		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	6.141378		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,488	310,081	978,407	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,722	63,337	123,385	0	0	52.00
53.00	05300	ANESTHESIOLOGY	742,838	2,593	740,245	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,273	365,391	1,614,882	0	0	54.00
56.00	05600	RADIOISOTOPE	139,319	24,845	114,474	0	0	56.00
60.00	06000	LABORATORY	2,150,938	194,846	1,956,092	0	0	60.00
60.02	06002	GEO PSYCH	307,319	30,256	277,063	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,882	1,852	54,030	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	489,317	63,350	425,967	0	0	65.00
66.00	06600	PHYSICAL THERAPY	165,167	22,126	143,041	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	214,783	80,401	134,382	0	0	69.00
69.01	06901	PULMONARY REHAB	144,494	23,833	120,661	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,686	36,343	418,343	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,595	5,940	172,655	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,827	129,469	1,272,358	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,683,363	509,562	8,173,801	0	0	88.00
90.00	09000	CLINIC	51,152	1,878	49,274	0	0	90.00
91.00	09100	EMERGENCY	2,670,419	212,261	2,458,158	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,455	82,295	334,160	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	178,493	19,324	159,169	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,900,530	2,179,983	19,720,547	0	0	200.00
201.00		Less Observation Beds	416,455	82,295	334,160	0	0	201.00
202.00		Total (line 200 minus line 201)	21,484,075	2,097,688	19,386,387	0	0	202.00

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

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,288,488	2,633,762	0.489220		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,722	197,913	0.943455		52.00
53.00	05300	ANESTHESIOLOGY	742,838	1,575,343	0.471540		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,273	10,939,875	0.181014		54.00
56.00	05600	RADIOISOTOPE	139,319	431,538	0.322843		56.00
60.00	06000	LABORATORY	2,150,938	10,995,607	0.195618		60.00
60.02	06002	GEO PSYCH	307,319	494,957	0.620900		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,882	77,746	0.718777		62.00
65.00	06500	RESPIRATORY THERAPY	489,317	948,934	0.515649		65.00
66.00	06600	PHYSICAL THERAPY	165,167	253,456	0.651659		66.00
69.00	06900	ELECTROCARDIOLOGY	214,783	709,498	0.302725		69.00
69.01	06901	PULMONARY REHAB	144,494	129,949	1.111929		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,686	706,491	0.643584		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,595	263,101	0.678808		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,827	2,701,420	0.518922		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,683,363	7,832,413	1.108645		88.00
90.00	09000	CLINIC	51,152	99,723	0.512941		90.00
91.00	09100	EMERGENCY	2,670,419	2,749,578	0.971210		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,455	698,009	0.596633		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	178,493	29,064	6.141378		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,900,530	44,468,377			200.00
201.00		Less Observation Beds	416,455	0			201.00
202.00		Total (line 200 minus line 201)	21,484,075	44,468,377			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/28/2018 3:03 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	310,081	2,633,762	0.117733	140,298	16,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,337	197,913	0.320024	424	136	52.00
53.00	05300	ANESTHESIOLOGY	2,593	1,575,343	0.001646	47,074	77	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	365,391	10,939,875	0.033400	295,970	9,885	54.00
56.00	05600	RADIOISOTOPE	24,845	431,538	0.057573	8,190	472	56.00
60.00	06000	LABORATORY	194,846	10,995,607	0.017720	307,039	5,441	60.00
60.02	06002	GEO PSYCH	30,256	494,957	0.061129	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,852	77,746	0.023821	24,535	584	62.00
65.00	06500	RESPIRATORY THERAPY	63,350	948,934	0.066759	144,222	9,628	65.00
66.00	06600	PHYSICAL THERAPY	22,126	253,456	0.087297	6,215	543	66.00
69.00	06900	ELECTROCARDIOLOGY	80,401	709,498	0.113321	17,742	2,011	69.00
69.01	06901	PULMONARY REHAB	23,833	129,949	0.183403	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,343	706,491	0.051442	172,467	8,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,940	263,101	0.022577	64,660	1,460	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,469	2,701,420	0.047926	307,132	14,720	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	509,562	7,832,413	0.065058	0	0	88.00
90.00	09000	CLINIC	1,878	99,723	0.018832	0	0	90.00
91.00	09100	EMERGENCY	212,261	2,749,578	0.077198	6,998	540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,295	698,009	0.117900	13,171	1,553	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	19,324	29,064	0.664878	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,179,983	44,468,377		1,556,137	72,440	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 3:03 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	731,270	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	731,270	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:03 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	2,633,762	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	197,913	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	731,270	0	1,575,343	0.464197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,939,875	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	431,538	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	10,995,607	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	494,957	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	77,746	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	948,934	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	253,456	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	709,498	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	129,949	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	706,491	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	263,101	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,701,420	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,832,413	0.000000	88.00
90.00	09000	CLINIC	0	0	0	99,723	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,749,578	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	698,009	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	29,064	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	731,270	0	44,468,377		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 3:03 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	140,298	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	424	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	47,074	21,852	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	295,970	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	8,190	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	307,039	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	24,535	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	144,222	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,215	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	17,742	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	172,467	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	64,660	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	307,132	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	6,998	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	13,171	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,556,137	21,852	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 3:03 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	0.489220	0	534,634	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.943455	0	983	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471540	0	326,804	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181014	0	3,604,525	0	0	54.00
56.00	05600	RADIOISOTOPE	0.322843	0	206,375	0	0	56.00
60.00	06000	LABORATORY	0.195618	0	3,264,557	0	0	60.00
60.02	06002	GEO PSYCH	0.620900	0	365,063	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.718777	0	20,635	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.515649	0	283,291	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651659	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.302725	0	261,730	0	0	69.00
69.01	06901	PULMONARY REHAB	1.111929	0	111,574	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.643584	0	83,052	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678808	0	21,251	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518922	0	690,210	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.512941	0	69,315	0	0	90.00
91.00	09100	EMERGENCY	0.971210	0	720,424	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.596633	0	258,371	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.141378	0	9,655	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	10,832,449	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	10,832,449	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 3:03 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	261,554	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	927	0		52.00
53.00	05300	ANESTHESIOLOGY	154,101	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,469	0		54.00
56.00	05600	RADIOISOTOPE	66,627	0		56.00
60.00	06000	LABORATORY	638,606	0		60.00
60.02	06002	GEO PSYCH	226,668	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,832	0		62.00
65.00	06500	RESPIRATORY THERAPY	146,079	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	79,232	0		69.00
69.01	06901	PULMONARY REHAB	124,062	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,451	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,425	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	358,165	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	35,555	0		90.00
91.00	09100	EMERGENCY	699,683	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,153	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	59,295	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,739,884	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,739,884	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 3:03 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	0.489220	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.943455	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471540	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181014	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.322843	0	0	0	0	56.00
60.00	06000	LABORATORY	0.195618	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.620900	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.718777	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.515649	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.651659	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.302725	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	1.111929	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.643584	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678808	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518922	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.512941	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.971210	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.596633	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.141378	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/28/2018 3:03 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GEO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	850,488	287,505	562,983	1,545	364.39	30.00
43.00	NURSERY	28,188		28,188	238	118.44	43.00
200.00	Total (lines 30 through 199)	878,676		591,171	1,783		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	251	91,462				30.00
43.00	NURSERY	135	15,989				43.00
200.00	Total (lines 30 through 199)	386	107,451				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	310,081	2,633,762	0.117733	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,337	197,913	0.320024	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,593	1,575,343	0.001646	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	365,391	10,939,875	0.033400	0	0	54.00
56.00	05600	RADIOISOTOPE	24,845	431,538	0.057573	0	0	56.00
60.00	06000	LABORATORY	194,846	10,995,607	0.017720	0	0	60.00
60.02	06002	GEO PSYCH	30,256	494,957	0.061129	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,852	77,746	0.023821	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	63,350	948,934	0.066759	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,126	253,456	0.087297	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	80,401	709,498	0.113321	0	0	69.00
69.01	06901	PULMONARY REHAB	23,833	129,949	0.183403	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,343	706,491	0.051442	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,940	263,101	0.022577	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,469	2,701,420	0.047926	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	509,562	7,832,413	0.065058	0	0	88.00
90.00	09000	CLINIC	1,878	99,723	0.018832	0	0	90.00
91.00	09100	EMERGENCY	212,261	2,749,578	0.077198	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,352	698,009	0.117981	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	19,324	29,064	0.664878	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,180,040	44,468,377		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,545	0.00	251	30.00
43.00	04300	NURSERY		0	238	0.00	135	43.00
200.00		Total (lines 30 through 199)		0	1,783		386	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	731,270	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	731,270	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

		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	2,633,762	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	197,913	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	731,270	0	1,575,343	0.464197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,939,875	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	431,538	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	10,995,607	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	494,957	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	77,746	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	948,934	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	253,456	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	709,498	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	129,949	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	706,491	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	263,101	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,701,420	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,832,413	0.000000	88.00
90.00	09000	CLINIC	0	0	0	99,723	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,749,578	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	698,009	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	29,064	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	731,270	0	44,468,377		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 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)	2,354	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,545	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)	1,319	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	319	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)	470	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	13	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	697	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)	289	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)	394	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	147.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	151.43	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,303,893	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)	1,029	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)	1,969	25.00
26.00	Total swing-bed cost (see instructions)	1,456,896	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,846,997	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)	2,846,997	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,842.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,284,369	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,284,369	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	637,861	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,922,230	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)	532,543	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	726,028	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,258,571	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)	226	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,842.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	416,455	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 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	850,488	4,303,893	0.197609	416,455	82,295	90.00
91.00	Nursing School cost	0	4,303,893	0.000000	416,455	0	91.00
92.00	Allied health cost	0	4,303,893	0.000000	416,455	0	92.00
93.00	All other Medical Education	0	4,303,893	0.000000	416,455	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,354	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,545	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)	1,319	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	789	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	1	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	251	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)	238	15.00
16.00	Nursery days (title V or XIX only)	135	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,303,893	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)	1,454,916	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,848,977	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)	2,848,977	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,844.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	462,844	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)	462,844	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	370,579	238	1,557.05	135	210,202	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)	673,046	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)	107,451	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)	107,451	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	565,595	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)	226	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,844.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	416,744	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	850,488	4,303,893	0.197609	416,744	82,352	90.00
91.00	Nursing School cost	0	4,303,893	0.000000	416,744	0	91.00
92.00	Allied health cost	0	4,303,893	0.000000	416,744	0	92.00
93.00	All other Medical Education	0	4,303,893	0.000000	416,744	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/28/2018 3:03 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		988,900		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.489220	140,298	68,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.943455	424	400	52.00
53.00	05300	ANESTHESIOLOGY	0.471540	47,074	22,197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181014	295,970	53,575	54.00
56.00	05600	RADIOISOTOPE	0.322843	8,190	2,644	56.00
60.00	06000	LABORATORY	0.195618	307,039	60,062	60.00
60.02	06002	GEO PSYCH	0.620900	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.718777	24,535	17,635	62.00
65.00	06500	RESPIRATORY THERAPY	0.515649	144,222	74,368	65.00
66.00	06600	PHYSICAL THERAPY	0.651659	6,215	4,050	66.00
69.00	06900	ELECTROCARDIOLOGY	0.302725	17,742	5,371	69.00
69.01	06901	PULMONARY REHAB	1.111929	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.643584	172,467	110,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678808	64,660	43,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518922	307,132	159,378	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.512941	0	0	90.00
91.00	09100	EMERGENCY	0.971210	6,998	6,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.596633	13,171	7,858	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.141378	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,556,137	637,861	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)		1,556,137		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/28/2018 3:03 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.489220	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.943455	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.471540	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.181014	23,660	4,283	54.00
56.00	05600	RADIOISOTOPE	0.322843	0	0	56.00
60.00	06000	LABORATORY	0.195618	95,875	18,755	60.00
60.02	06002	GEO PSYCH	0.620900	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.718777	975	701	62.00
65.00	06500	RESPIRATORY THERAPY	0.515649	64,059	33,032	65.00
66.00	06600	PHYSICAL THERAPY	0.651659	192,674	125,558	66.00
69.00	06900	ELECTROCARDIOLOGY	0.302725	401	121	69.00
69.01	06901	PULMONARY REHAB	1.111929	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.643584	52,700	33,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.678808	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.518922	136,657	70,914	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.512941	0	0	90.00
91.00	09100	EMERGENCY	0.971210	52	51	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.596633	176	105	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.141378	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		567,229	287,437	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)		567,229		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 3:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,739,884	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)	3,739,884	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)	3,777,283	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)	34,331	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,524,382	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)	2,218,570	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)	2,218,570	30.00
31.00	Primary payer payments	1,086	31.00
32.00	Subtotal (line 30 minus line 31)	2,217,484	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)	142,253	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	92,464	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	142,253	36.00
37.00	Subtotal (see instructions)	2,309,948	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)	2,309,948	40.00
40.01	Sequestration adjustment (see instructions)	46,199	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,930,418	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-666,669	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2018 3:03 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		1,782,483		2,997,429	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	06/27/2018	77,294		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	06/27/2018	67,011	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)		77,294		-67,011	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,859,777		2,930,418	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		176,660		666,669	6.02
7.00	Total Medicare program liability (see instructions)		1,683,117		2,263,749	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2018 3:03 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		1,628,966		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	06/27/2018	56,771		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)		56,771		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,685,737		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		179,062		0	6.02
7.00	Total Medicare program liability (see instructions)		1,506,675		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 3:03 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: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/28/2018 3:03 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)	1,271,157	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)	290,311	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	683	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,561,468	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,561,468	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,561,468	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	24,045	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,537,423	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,537,423	0	19.00
19.01	Sequestration adjustment (see instructions)	30,748	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,685,737	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)	-179,062	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/28/2018 3:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,922,230	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)	1,922,230	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,941,452	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)	1,941,452	19.00
20.00	Deductibles (exclude professional component)	232,652	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,708,800	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,708,800	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,333	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,666	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,333	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,717,466	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)	1,717,466	30.00
30.01	Sequestration adjustment (see instructions)	34,349	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,859,777	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)	-176,660	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/28/2018 3:03 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	3,402,717	0	0	0	1.00
2.00	Temporary investments	53,585	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,838,086	0	0	0	4.00
5.00	Other receivable	336,669	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	371,122	0	0	0	7.00
8.00	Prepaid expenses	266,200	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,268,379	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	499,957	0	0	0	12.00
13.00	Land improvements	1,336,532	0	0	0	13.00
14.00	Accumulated depreciation	-389,840	0	0	0	14.00
15.00	Buildings	24,928,402	0	0	0	15.00
16.00	Accumulated depreciation	-11,122,811	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,028,133	0	0	0	23.00
24.00	Accumulated depreciation	-5,020,880	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	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,775,183	0	0	0	28.00
29.00	Minor equipment-nondepreciable	12,600	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,465,679	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,454,556	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	853,344	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,307,900	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,041,958	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,115,131	0	0	0	37.00
38.00	Salaries, wages, and fees payable	907,410	0	0	0	38.00
39.00	Payroll taxes payable	85,193	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,137,064	0	0	0	40.00
41.00	Deferred income	31,094	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	66,560	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,342,452	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	20,314,705	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,314,705	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,657,157	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,384,801				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)	13,384,801	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,041,958	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/28/2018 3:03 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		13,703,574		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-325,348				2.00
3.00	Total (sum of line 1 and line 2)		13,378,226		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	6,575		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)		6,575		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,384,801		0		11.00
12.00	CAPITAL CAMPAIGN EXPENSE	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,384,801		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	RESTRICTED CONTRIBUTIONS		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	CAPITAL CAMPAIGN EXPENSE		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: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2018 3:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,073,992		3,073,992	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,073,992		3,073,992	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)	3,073,992		3,073,992	17.00
18.00	Ancillary services	4,863,073	28,020,849	32,883,922	18.00
19.00	Outpatient services	90,160	7,382,803	7,472,963	19.00
20.00	RURAL HEALTH CLINIC	0	7,832,413	7,832,413	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	33,593	33,593	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,027,225	43,269,658	51,296,883	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,832,745		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)		28,832,745		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/28/2018 3:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,296,883	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,746,996	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,549,887	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,832,745	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,282,858	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	123,121	6.00
7.00	Income from investments	467,865	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	3,385	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	36,356	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,844	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	54,166	22.00
23.00	Governmental appropriations	53,433	23.00
24.00	HOSPITAL OTHER INCOME	13,581	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	RELEASED FROM RESTRICTION	0	24.03
24.04	340B PHARMACY REVENUE	1,050,863	24.04
24.05	SALARY REIMBURSEMENTS	88,888	24.05
24.06	EHR INCENTIVE	158,347	24.06
25.00	Total other income (sum of lines 6-24)	2,052,849	25.00
26.00	Total (line 5 plus line 25)	-230,009	26.00
27.00	LOSS ON DISPOSAL	67,122	27.00
27.01	EQUITY IN EARNINGS OF UNCONCOLIDATED	28,217	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	95,339	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-325,348	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/28/2018 3:03 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	1,714,920	0	1,714,920	-168,851	1,546,069	1.00
2.00	Physician Assistant	119,477	0	119,477	0	119,477	2.00
3.00	Nurse Practitioner	1,125,791	0	1,125,791	0	1,125,791	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,403,330	0	1,403,330	63,543	1,466,873	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,363,518	0	4,363,518	-105,308	4,258,210	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	660,593	660,593	0	660,593	12.00
13.00	Other Costs Under Agreement	0	28,700	28,700	0	28,700	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	689,293	689,293	0	689,293	14.00
15.00	Medical Supplies	0	387,605	387,605	0	387,605	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	50,980	50,980	0	50,980	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	438,585	438,585	0	438,585	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,363,518	1,127,878	5,491,396	-105,308	5,386,088	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	431,684	431,684	0	431,684	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	431,684	431,684	0	431,684	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,363,518	1,559,562	5,923,080	-105,308	5,817,772	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/28/2018 3:03 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	1,546,069		1.00
2.00	Physician Assistant	0	119,477		2.00
3.00	Nurse Practitioner	0	1,125,791		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,466,873		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,258,210		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	660,593		12.00
13.00	Other Costs Under Agreement	0	28,700		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	689,293		14.00
15.00	Medical Supplies	0	387,605		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	50,980		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	438,585		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	5,386,088		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-29,715	401,969		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-29,715	401,969		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-29,715	5,788,057		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/28/2018 3:03 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	2.66	9,852	4,200	11,172		1.00
2.00	Physician Assistant	0.64	2,840	2,100	1,344		2.00
3.00	Nurse Practitioner	7.73	17,953	2,100	16,233		3.00
4.00	Subtotal (sum of lines 1 through 3)	11.03	30,645		28,749	30,645	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	11.03	30,645			30,645	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)					5,386,088	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)					5,386,088	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)					401,969	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,895,306	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,297,275	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,297,275	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,297,275	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,683,363	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/28/2018 3:03 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)			8,683,363	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			159,470	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,523,893	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			30,645	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)			30,645	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			278.15	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)	278.15	278.15		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,155		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,712,013		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,712,013		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,279,630		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		101,198		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		135,393		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.)		1,158,092		16.04
16.05	Total program cost (see instructions)	0	1,293,485		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		129,005		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		209,885		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,293,485		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66,512		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,359,997		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,359,997		26.00
26.01	Sequestration adjustment (see instructions)		27,200		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		888,642		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)		444,155		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

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

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/28/2018 3:03 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)	4,258,210	4,258,210	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000992	0.001857	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,224	7,907	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	67,923	18,862	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	72,147	26,769	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,386,088	5,386,088	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,297,275	3,297,275	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013395	0.004970	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	44,167	16,387	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	116,314	43,156	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	454	850	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	256.20	50.77	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	196	321	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	50,215	16,297	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)		159,470	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)		66,512	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/28/2018 3:03 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		885,806	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		06/27/2018	2,836	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		2,836	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		888,642	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		444,155	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,332,797	7.00

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