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: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 10/24/2018 2:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/24/2018 Time: 2:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (14-1329) 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	-1,906	-127,976	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	78,059	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		37,082		0	10.00
200.00	Total	0	76,153	-90,894	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2018 1:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	11		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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2018 1:28 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2018 1:28 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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2018 1:28 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)	N		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

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

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

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

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

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

		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:	339,517	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 10/24/2018 1:28 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 10/24/2018 1:28 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 10/24/2018 1:28 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/13/2018	Y	09/13/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 10/24/2018 1:28 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	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.	DAN		LINHART		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404		DAN.LINHART@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 10/24/2018 1:28 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.	MANAGER		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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2018 1:28 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	4,128.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	4,128.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	4,128.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2018 1:28 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)	107	9	172			1.00
2.00	HMO and other (see instructions)	9	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	1,772	0	2,172			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	510			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,879	9	2,854			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)	1,879	9	2,854	0.00	111.14	14.00
15.00	CAH visits	2,345	1,015	6,536			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,939	4,411	17,580	0.00	18.56	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	129.70	27.00
28.00	Observation Bed Days		10	123			28.00
29.00	Ambulance Trips	248					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2018 1:28 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	47	5	77	1.00
2.00	HMO and other (see instructions)			4	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	47	5	77	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 10/24/2018 1:28 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			300 NORTH JACKSON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MORRISON		IL	61270	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	08:00	20:00	08:00	20:00	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.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		WHITESIDE				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1329
Component CCN: 14-3981

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-8
Date/Time Prepared:
10/24/2018 1:28 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 10/24/2018 1:28 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)	0.664577	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,196,529	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,269,935	6.00
7.00	Medicaid cost (line 1 times line 6)	2,173,124	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)	976,595	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	976,595	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)	18,506	38,481	56,987	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	12,299	38,481	50,780	21.00
22.00	Payments received from patients for amounts previously written off as charity care	999	8,189	9,188	22.00
23.00	Cost of charity care (line 21 minus line 22)	11,300	30,292	41,592	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)	926,343	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	109,795	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	168,916	27.01
28.00	Non-Medicare bad debt expense (see instructions)	757,427	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	562,490	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	604,082	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,580,677	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		502,637	502,637	-40,449	462,188	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		140,995	140,995	187,028	328,023	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,579,427	1,579,427	-163,864	1,415,563	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	32,483	3,078	35,561	0	35,561	5.01
5.02	00591	PERSONNEL	100,250	8,945	109,195	0	109,195	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	322,360	98,878	421,238	0	421,238	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	473,902	506,895	980,797	256,327	1,237,124	5.05
7.00	00700	OPERATION OF PLANT	167,267	378,032	545,299	0	545,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,124	23,124	0	23,124	8.00
9.00	00900	HOUSEKEEPING	162,953	22,168	185,121	0	185,121	9.00
10.00	01000	DIETARY	200,892	98,731	299,623	0	299,623	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	140,653	12,367	153,020	0	153,020	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,056	35,006	59,062	0	59,062	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249,545	44,526	294,071	0	294,071	16.00
17.00	01700	SOCIAL SERVICE	70,511	1,004	71,515	0	71,515	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,402,350	162,393	1,564,743	-4,996	1,559,747	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	304,110	195,831	499,941	10,841	510,782	50.00
53.00	05300	ANESTHESIOLOGY	0	223,896	223,896	-108	223,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,919	174,361	523,280	749	524,029	54.00
60.00	06000	LABORATORY	371,707	408,759	780,466	0	780,466	60.00
64.00	06400	INTRAVENOUS THERAPY	0	36,660	36,660	18,879	55,539	64.00
65.00	06500	RESPIRATORY THERAPY	0	51,603	51,603	-46,723	4,880	65.00
66.00	06600	PHYSICAL THERAPY	267,388	4,095	271,483	0	271,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,812	674	208,486	0	208,486	67.00
68.00	06800	SPEECH PATHOLOGY	602	7,875	8,477	0	8,477	68.00
69.00	06900	ELECTROCARDIOLOGY	2,442	10,067	12,509	0	12,509	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,527	8,527	52,376	60,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	332,315	332,315	0	332,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,564	316,771	455,335	0	455,335	73.00
76.00	03950	NEUROLOGY	0	10,463	10,463	0	10,463	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,091,116	614,047	2,705,163	99,952	2,805,115	88.00
91.00	09100	EMERGENCY	371,688	1,595,836	1,967,524	-266,563	1,700,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	56,675	10,674	67,349	0	67,349	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	118,733	40,386	159,119	-5,145	153,974	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		98,304	98,304	-98,304	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,626,978	7,759,350	15,386,328	0	15,386,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	7,626,978	7,759,350	15,386,328	0	15,386,328	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	462,188		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-50,401	277,622		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,729	1,410,834		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	35,561		5.01
5.02	00591	PERSONNEL	0	109,195		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-19,765	401,473		5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-22,090	1,215,034		5.05
7.00	00700	OPERATION OF PLANT	0	545,299		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,124		8.00
9.00	00900	HOUSEKEEPING	0	185,121		9.00
10.00	01000	DIETARY	-68,903	230,720		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	153,020		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,062		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,255	287,816		16.00
17.00	01700	SOCIAL SERVICE	0	71,515		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,559,747		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-120,624	390,158		50.00
53.00	05300	ANESTHESIOLOGY	-155,443	68,345		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-12,790	511,239		54.00
60.00	06000	LABORATORY	-25,910	754,556		60.00
64.00	06400	INTRAVENOUS THERAPY	-692	54,847		64.00
65.00	06500	RESPIRATORY THERAPY	-7	4,873		65.00
66.00	06600	PHYSICAL THERAPY	-14,050	257,433		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	208,486		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,477		68.00
69.00	06900	ELECTROCARDIOLOGY	-8,449	4,060		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-52	60,851		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	332,315		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,257	446,078		73.00
76.00	03950	NEUROLOGY	0	10,463		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-84,644	2,720,471		88.00
91.00	09100	EMERGENCY	-185,988	1,514,973		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	-3,383	63,966		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	153,974		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-793,432	14,592,896		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-793,432	14,592,896		200.00

RECLASSIFICATIONS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 10/24/2018 1:28 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	87,585	1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	4,947	2.00
3.00	OPERATING ROOM	50.00	0	5,023	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	749	4.00
	TOTALS		0	98,304	
	B - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,038	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,956	2.00
3.00	ADMINISTRATIVE & GENERAL	5.05	0	251,380	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	310,374	
	C - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	175,072	1.00
	TOTALS		0	175,072	
	D - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	52,376	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	52,376	
	E - RHC PHYSICIAN IN ER				
1.00	RURAL HEALTH CLINIC	88.00	0	70	1.00
	TOTALS		0	70	
	F - IV THERAPY SALARIES				
1.00	INTRAVENOUS THERAPY	64.00	18,879	0	1.00
	TOTALS		18,879	0	
	G - PHYSICIAN BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	158,046	1.00
2.00	OPERATING ROOM	50.00	0	5,818	2.00
	TOTALS		0	163,864	
500.00	Grand Total: Increases		18,879	800,060	500.00

RECLASSIFICATIONS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 10/24/2018 1:28 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	98,304	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	98,304			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	246,957	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	58,164	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	5,145	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	108	0		4.00
	TOTALS		0	310,374			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	175,072	9		1.00
	TOTALS		0	175,072			
	D - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,996	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	46,723	0		2.00
3.00	EMERGENCY	91.00	0	657	0		3.00
	TOTALS		0	52,376			
	E - RHC PHYSICIAN IN ER						
1.00	EMERGENCY	91.00	0	70	0		1.00
	TOTALS		0	70			
	F - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	18,879	0	0		1.00
	TOTALS		18,879	0			
	G - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	163,864	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	163,864			
500.00	Grand Total: Decreases		18,879	800,060			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0	0	0	0	1.00
2.00	Land Improvements	431,331	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,455,457	404,815	0	404,815	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	824,347	0	0	0	0	5.00
6.00	Movable Equipment	4,970,233	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,703,025	404,815	0	404,815	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,703,025	404,815	0	404,815	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	21,657	0	1.00
2.00	Land Improvements	431,331	0	2.00
3.00	Buildings and Fixtures	9,860,272	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	824,347	0	5.00
6.00	Movable Equipment	4,970,233	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,107,840	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,107,840	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 10/24/2018 1:28 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	502,637	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	140,995	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	643,632	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	502,637	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	140,995	2.00
3.00	Total (sum of lines 1-2)	0	643,632	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 10/24/2018 1:28 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,137,607	0	11,137,607	0.691440	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,970,233	0	4,970,233	0.308560	0	2.00
3.00	Total (sum of lines 1-2)	16,107,840	0	16,107,840	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	327,565	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	265,666	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	593,231	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	87,585	47,038	0	0	462,188	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,956	0	0	277,622	2.00
3.00	Total (sum of lines 1-2)	87,585	58,994	0	0	739,810	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 10/24/2018 1:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,222	ADMINISTRATIVE & GENERAL	5.05	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	-507,795			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	-60,674	DIETARY	10.00	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	-6,255	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 10/24/2018 1:28 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-50,401	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CATERING REVENUE	B	-8,229	DIETARY	10.00	0	33.00
33.01	LAB OTHER REVENUE	B	-16,666	LABORATORY	60.00	0	33.01
33.02	REHAB MISC REV	B	-12,455	PHYSICAL THERAPY	66.00	0	33.02
33.03	OTHER REV -A&G	B	-1,127	ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04	NONALLOWABLE DUES	B	-5,563	ADMINISTRATIVE & GENERAL	5.05	0	33.04
33.05	PATIENT TELEPHONE - SALARIES	A	-4,295	ADMINISTRATIVE & GENERAL	5.05	0	33.05
33.06	PATIENT TELEPHONE - BENEFITS	A	-636	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PHYSICIAN BILLING SALARIES	A	-19,765	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.07
33.08	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-4,093	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	PHARMACY DRUG RETAIL 340B	A	-7,926	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.10	ADVERTISING	A	-9,858	ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11	OTHER REV- EDUCATION	A	-25	ADMINISTRATIVE & GENERAL	5.05	0	33.11
33.12	SELF INSURANCE EXPENSE	A	-11,051	OPERATING ROOM	50.00	0	33.12
33.13	SELF INSURANCE EXPENSE	A	-6,893	ANESTHESIOLOGY	53.00	0	33.13
33.14	SELF INSURANCE EXPENSE	A	-5,270	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-9,244	LABORATORY	60.00	0	33.15
33.16	SELF INSURANCE EXPENSE	A	-692	INTRAVENOUS THERAPY	64.00	0	33.16
33.17	SELF INSURANCE EXPENSE	A	-7	RESPIRATORY THERAPY	65.00	0	33.17
33.18	SELF INSURANCE EXPENSE	A	-1,595	PHYSICAL THERAPY	66.00	0	33.18
33.19	SELF INSURANCE EXPENSE	A	-39	ELECTROCARDIOLOGY	69.00	0	33.19
33.20	SELF INSURANCE EXPENSE	A	-52	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.20
33.21	SELF INSURANCE EXPENSE	A	-1,331	DRUGS CHARGED TO PATIENTS	73.00	0	33.21
33.22	SELF INSURANCE EXPENSE	A	-5,252	EMERGENCY	91.00	0	33.22
33.23	SELF INSURANCE EXPENSE	A	-31,618	RURAL HEALTH CLINIC	88.00	0	33.23
33.24	SELF INSURANCE EXPENSE	A	-3,383	WOUND CARE	93.00	0	33.24
33.25	OTHER DEPT REV RADIOLOGY	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-793,432				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 10/24/2018 1:28 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	91.00	EMERGENCY	1,264,054	180,736	1,083,318	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	28,350	0	28,350	0	0	2.00
3.00	60.00	LABORATORY	15,000	0	15,000	0	0	3.00
4.00	91.00	EMERGENCY	9,450	0	9,450	0	0	4.00
5.00	50.00	OPERATING ROOM	21,445	21,445	0	0	0	5.00
6.00	50.00	OPERATING ROOM	77,665	77,665	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	7,500	7,500	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	8,410	8,410	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	45,536	45,536	0	0	0	9.00
10.00	50.00	OPERATING ROOM	10,463	10,463	0	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	7,490	7,490	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	148,550	148,550	0	0	0	12.00
200.00			1,643,913	507,795	1,136,118		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	12.00
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	91.00	EMERGENCY	0	0	0	180,736		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	21,445		5.00
6.00	50.00	OPERATING ROOM	0	0	0	77,665		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,500		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,410		8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	45,536		9.00
10.00	50.00	OPERATING ROOM	0	0	0	10,463		10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	7,490		11.00
12.00	53.00	ANESTHESIOLOGY	0	0	0	148,550		12.00
200.00			0	0	0	507,795		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/24/2018 1:28 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					50	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	67.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	94.92	75.93	56.95	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)	37.97	37.97	28.48			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)					5,125	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)					5,125	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)					5,125	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					75.93	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					27,335	22.00
23.00	Total salary equivalency (see instructions)					27,335	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)					1,899	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)					1,899	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)					278	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,177	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)					2,177	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/24/2018 1:28 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.93	56.95	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)	27,335		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,177		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)	29,512		63.00
64.00	Total cost of outside supplier services (from your records)	7,875		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	1,899		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	278		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,177		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	278		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	278		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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	462,188	462,188				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	277,622		277,622			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,410,834	0	0	1,410,834		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	35,561	13,752	0	7,619	56,932	5.01
5.02	00591	PERSONNEL	109,195	2,812	0	23,515	25	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	401,473	8,315	0	70,977	811	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,215,034	24,968	17,056	110,151	3,422	5.05
7.00	00700	OPERATION OF PLANT	545,299	85,015	2,064	39,234	1,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,124	10,826	0	0	0	8.00
9.00	00900	HOUSEKEEPING	185,121	4,519	0	38,222	203	9.00
10.00	01000	DIETARY	230,720	12,517	229	47,121	583	10.00
11.00	01100	CAFETERIA	0	4,820	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	153,020	4,999	0	32,992	203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,062	4,226	0	5,643	13,207	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	287,816	10,761	575	58,534	887	16.00
17.00	01700	SOCIAL SERVICE	71,515	1,244	0	16,539	25	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,559,747	75,937	36,558	328,935	3,447	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	390,158	19,100	82,227	53,115	6,438	50.00
53.00	05300	ANESTHESIOLOGY	68,345	0	0	0	431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	511,239	13,077	121,990	81,843	1,496	54.00
60.00	06000	LABORATORY	754,556	12,378	5,798	87,188	1,445	60.00
64.00	06400	INTRAVENOUS THERAPY	54,847	0	0	4,428	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,873	0	724	0	0	65.00
66.00	06600	PHYSICAL THERAPY	257,433	21,213	0	62,719	1,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,486	4,023	0	48,745	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,477	992	0	141	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,060	0	1,672	573	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	60,851	0	0	0	1,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	332,315	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	446,078	3,934	307	32,502	507	73.00
76.00	03950	NEUROLOGY	10,463	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,720,471	85,665	5,494	136,199	7,452	88.00
91.00	09100	EMERGENCY	1,514,973	10,729	2,928	82,755	5,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	63,966	2,495	0	13,294	3,498	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	153,974	22,920	0	27,850	3,853	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,592,896	461,237	277,622	1,410,834	56,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	951	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	14,592,896	462,188	277,622	1,410,834	56,932	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	135,547					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,831	487,407				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	8,571	0	1,379,202	1,379,202		5.05
7.00	00700	OPERATION OF PLANT	3,025	0	676,133	70,573	746,706	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	33,950	3,544	24,697	8.00
9.00	00900	HOUSEKEEPING	2,947	0	231,012	24,112	10,309	9.00
10.00	01000	DIETARY	3,634	0	294,804	30,771	28,553	10.00
11.00	01100	CAFETERIA	0	0	4,820	503	10,995	11.00
13.00	01300	NURSING ADMINISTRATION	2,544	0	193,758	20,224	11,403	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	435	0	82,573	8,619	9,641	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,514	0	363,087	37,898	24,548	16.00
17.00	01700	SOCIAL SERVICE	1,275	0	90,598	9,456	2,837	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,364	35,436	2,065,424	215,583	173,230	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,500	61,081	617,619	64,465	43,572	50.00
53.00	05300	ANESTHESIOLOGY	0	5,930	74,706	7,798	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,311	71,968	807,924	84,329	29,833	54.00
60.00	06000	LABORATORY	6,723	64,269	932,357	97,317	28,238	60.00
64.00	06400	INTRAVENOUS THERAPY	341	20,112	79,728	8,322	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,366	9,963	1,040	0	65.00
66.00	06600	PHYSICAL THERAPY	4,836	24,273	371,944	38,822	48,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,759	13,139	278,152	29,033	9,178	67.00
68.00	06800	SPEECH PATHOLOGY	11	437	10,058	1,050	2,262	68.00
69.00	06900	ELECTROCARDIOLOGY	44	3,325	9,674	1,010	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,730	67,595	7,055	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,636	347,951	36,318	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,506	50,374	536,208	55,968	8,974	73.00
76.00	03950	NEUROLOGY	0	460	10,923	1,140	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,822	63,982	3,057,085	319,083	195,423	88.00
91.00	09100	EMERGENCY	6,381	30,717	1,653,502	172,588	24,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	1,025	2,578	86,856	9,066	5,692	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,148	13,594	224,339	23,416	52,286	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,547	487,407	14,591,945	1,379,103	744,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	951	99	2,169	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	135,547	487,407	14,592,896	1,379,202	746,706	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,191					8.00
9.00	00900	HOUSEKEEPING	0	265,433				9.00
10.00	01000	DIETARY	0	1,483	355,611			10.00
11.00	01100	CAFETERIA	0	0	220,201	236,519		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,682	0	4,943	232,010	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,701	0	2,151	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,939	0	17,902	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,383	0	2,561	4,684	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,258	83,009	132,054	71,249	130,315	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,566	14,808	0	9,553	17,485	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,605	13,108	0	14,778	0	54.00
60.00	06000	LABORATORY	0	13,768	0	16,468	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	282	509	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,009	23,613	0	9,092	16,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,475	0	5,430	9,944	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,103	0	26	29	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	205	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,670	0	4,866	8,915	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,601	78,199	0	47,534	0	88.00
91.00	09100	EMERGENCY	10,562	11,942	0	21,437	39,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	1,492	0	2,356	4,292	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,590	0	0	5,686	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,191	264,375	352,255	236,519	232,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,058	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	3,356	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)	62,191	265,433	355,611	236,519	232,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,685					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	449,374				16.00
17.00	01700	SOCIAL SERVICE	0	0	111,519			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,669	111,519	3,042,310	-47,896	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,651	61,314	0	909,033	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,097	0	91,601	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,452	0	1,016,029	0	54.00
60.00	06000	LABORATORY	0	55,623	0	1,143,771	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	17,406	0	106,247	47,896	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,779	0	14,782	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,008	0	532,498	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,371	0	347,583	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	378	0	14,906	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,717	0	14,606	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,959	0	79,609	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,532	0	397,801	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,597	0	662,198	0	73.00
76.00	03950	NEUROLOGY	0	601	0	12,664	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35,159	59,492	0	3,797,576	0	88.00
91.00	09100	EMERGENCY	875	36,383	0	1,970,982	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	2,231	0	111,985	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,765	0	319,082	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,685	449,374	111,519	14,585,263	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	4,277	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	3,356	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)	107,685	449,374	111,519	14,592,896	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,994,414		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	909,033		50.00
53.00	05300	ANESTHESIOLOGY	91,601		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,029		54.00
60.00	06000	LABORATORY	1,143,771		60.00
64.00	06400	INTRAVENOUS THERAPY	154,143		64.00
65.00	06500	RESPIRATORY THERAPY	14,782		65.00
66.00	06600	PHYSICAL THERAPY	532,498		66.00
67.00	06700	OCCUPATIONAL THERAPY	347,583		67.00
68.00	06800	SPEECH PATHOLOGY	14,906		68.00
69.00	06900	ELECTROCARDIOLOGY	14,606		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	397,801		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	662,198		73.00
76.00	03950	NEUROLOGY	12,664		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	3,797,576		88.00
91.00	09100	EMERGENCY	1,970,982		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	111,985		93.00
93.01	04951	DIABETIC EDUCATION	0		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	319,082		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,585,263		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	0		194.00
194.01	07951	RENTAL SPACE	4,277		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	3,356		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	14,592,896		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	13,752	0	13,752	0	5.01
5.02	00591	PERSONNEL	0	2,812	0	2,812	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	8,315	0	8,315	0	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	24,968	17,056	42,024	0	5.05
7.00	00700	OPERATION OF PLANT	0	85,015	2,064	87,079	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,826	0	10,826	0	8.00
9.00	00900	HOUSEKEEPING	0	4,519	0	4,519	0	9.00
10.00	01000	DIETARY	0	12,517	229	12,746	0	10.00
11.00	01100	CAFETERIA	0	4,820	0	4,820	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,999	0	4,999	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,226	0	4,226	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,761	575	11,336	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,244	0	1,244	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	75,937	36,558	112,495	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,100	82,227	101,327	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,077	121,990	135,067	0	54.00
60.00	06000	LABORATORY	0	12,378	5,798	18,176	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	724	724	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,213	0	21,213	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,023	0	4,023	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	992	0	992	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,672	1,672	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,934	307	4,241	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	85,665	5,494	91,159	0	88.00
91.00	09100	EMERGENCY	0	10,729	2,928	13,657	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	0	2,495	0	2,495	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	22,920	0	22,920	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	461,237	277,622	738,859	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	951	0	951	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	462,188	277,622	739,810	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	13,752					5.01
5.02	00591	PERSONNEL	6	2,818				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	196	121	8,632			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	827	178	0	43,029		5.05
7.00	00700	OPERATION OF PLANT	361	63	0	2,201	89,704	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	111	2,967	8.00
9.00	00900	HOUSEKEEPING	49	61	0	752	1,238	9.00
10.00	01000	DIETARY	141	76	0	960	3,430	10.00
11.00	01100	CAFETERIA	0	0	0	16	1,321	11.00
13.00	01300	NURSING ADMINISTRATION	49	53	0	631	1,370	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,191	9	0	269	1,158	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	214	94	0	1,182	2,949	16.00
17.00	01700	SOCIAL SERVICE	6	27	0	295	341	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	833	527	628	6,725	20,811	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,555	114	1,082	2,011	5,234	50.00
53.00	05300	ANESTHESIOLOGY	104	0	105	243	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361	131	1,274	2,631	3,584	54.00
60.00	06000	LABORATORY	349	140	1,138	3,036	3,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7	356	260	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	77	32	0	65.00
66.00	06600	PHYSICAL THERAPY	355	101	430	1,211	5,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	78	233	906	1,103	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8	33	272	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	59	31	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	245	0	101	220	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	277	1,133	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122	52	892	1,746	1,078	73.00
76.00	03950	NEUROLOGY	0	0	8	36	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,800	786	1,133	9,958	23,476	88.00
91.00	09100	EMERGENCY	1,212	133	544	5,384	2,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	845	21	46	283	684	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	931	45	241	730	6,281	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,752	2,818	8,632	43,026	89,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	3	261	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	13,752	2,818	8,632	43,029	89,704	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,904					8.00
9.00	00900	HOUSEKEEPING	0	6,619				9.00
10.00	01000	DIETARY	0	37	17,390			10.00
11.00	01100	CAFETERIA	0	0	10,768	16,925		11.00
13.00	01300	NURSING ADMINISTRATION	0	42	0	354	7,498	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	117	0	154	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148	0	1,281	0	16.00
17.00	01700	SOCIAL SERVICE	0	34	0	183	151	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,541	2,070	6,458	5,098	4,213	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,915	369	0	684	565	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806	327	0	1,057	0	54.00
60.00	06000	LABORATORY	0	343	0	1,178	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	20	16	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	673	589	0	651	537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	112	0	389	321	67.00
68.00	06800	SPEECH PATHOLOGY	0	28	0	2	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92	0	348	288	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,252	1,950	0	3,401	0	88.00
91.00	09100	EMERGENCY	2,361	298	0	1,534	1,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	37	0	169	139	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	356	0	0	407	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,904	6,593	17,226	16,925	7,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	26	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	164	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)	13,904	6,619	17,390	16,925	7,498	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,124					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,204				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,281			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,173	2,281	169,853	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,071	2,346	0	123,273	0	50.00
53.00	05300	ANESTHESIOLOGY	0	348	0	800	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,401	0	147,639	0	54.00
60.00	06000	LABORATORY	0	2,128	0	29,880	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	666	0	1,325	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	145	0	978	0	65.00
66.00	06600	PHYSICAL THERAPY	0	804	0	32,378	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	435	0	7,600	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	14	0	1,350	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	142	0	1,920	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	190	0	756	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	518	0	1,928	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,668	0	10,527	0	73.00
76.00	03950	NEUROLOGY	0	23	0	67	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,979	2,276	0	140,170	0	88.00
91.00	09100	EMERGENCY	74	1,392	0	30,796	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	85	0	4,804	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	450	0	32,361	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,124	17,204	2,281	738,405	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	1,241	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	164	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)	9,124	17,204	2,281	739,810	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	169,853		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	123,273		50.00
53.00	05300	ANESTHESIOLOGY	800		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,639		54.00
60.00	06000	LABORATORY	29,880		60.00
64.00	06400	INTRAVENOUS THERAPY	1,325		64.00
65.00	06500	RESPIRATORY THERAPY	978		65.00
66.00	06600	PHYSICAL THERAPY	32,378		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,600		67.00
68.00	06800	SPEECH PATHOLOGY	1,350		68.00
69.00	06900	ELECTROCARDIOLOGY	1,920		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	756		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,928		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,527		73.00
76.00	03950	NEUROLOGY	67		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	140,170		88.00
91.00	09100	EMERGENCY	30,796		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	4,804		93.00
93.01	04951	DIABETIC EDUCATION	0		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	32,361		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	738,405		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	0		194.00
194.01	07951	RENTAL SPACE	1,241		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	164		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	739,810		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,866					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		265,666				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,014,791			4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,692	0	32,483	2,246		5.01
5.02	00591	PERSONNEL	346	0	100,250	1	7,494,245	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,023	0	302,595	32	322,360	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	3,072	16,321	469,607	135	473,902	5.05
7.00	00700	OPERATION OF PLANT	10,460	1,975	167,267	59	167,267	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	556	0	162,953	8	162,953	9.00
10.00	01000	DIETARY	1,540	219	200,892	23	200,892	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	140,653	8	140,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	24,056	521	24,056	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	550	249,545	35	249,545	16.00
17.00	01700	SOCIAL SERVICE	153	0	70,511	1	70,511	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,343	34,984	1,402,350	136	1,402,350	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350	78,686	226,445	254	304,110	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609	116,737	348,919	59	348,919	54.00
60.00	06000	LABORATORY	1,523	5,548	371,707	57	371,707	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	18,879	0	18,879	64.00
65.00	06500	RESPIRATORY THERAPY	0	693	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,610	0	267,388	58	267,388	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	207,812	0	207,812	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	602	0	602	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	2,442	0	2,442	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40	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	484	294	138,564	20	138,564	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,540	5,257	580,654	294	2,091,116	88.00
91.00	09100	EMERGENCY	1,320	2,802	352,809	198	352,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	56,675	138	56,675	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	0	118,733	152	118,733	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,749	265,666	6,014,791	2,246	7,494,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	462,188	277,622	1,410,834	56,932	135,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.127669	1.045004	0.234561	25.348175	0.018087	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	13,752	2,818	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	6.122885	0.000376	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.05	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	22,077,253					5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	-1,379,202	13,213,694			5.05
7.00	00700	OPERATION OF PLANT	0	0	676,133	40,273		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	33,950	1,332	9,816	8.00
9.00	00900	HOUSEKEEPING	0	0	231,012	556	0	9.00
10.00	01000	DIETARY	0	0	294,804	1,540	0	10.00
11.00	01100	CAFETERIA	0	0	4,820	593	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	193,758	615	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	82,573	520	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	363,087	1,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	90,598	153	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,605,114	0	2,065,424	9,343	4,618	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,766,718	0	617,619	2,350	1,352	50.00
53.00	05300	ANESTHESIOLOGY	268,590	0	74,706	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,259,577	0	807,924	1,609	569	54.00
60.00	06000	LABORATORY	2,911,127	0	932,357	1,523	0	60.00
64.00	06400	INTRAVENOUS THERAPY	910,983	0	79,728	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	197,773	0	9,963	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,099,477	0	371,944	2,610	475	66.00
67.00	06700	OCCUPATIONAL THERAPY	595,123	0	278,152	495	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,792	0	10,058	122	0	68.00
69.00	06900	ELECTROCARDIOLOGY	150,599	0	9,674	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	259,543	0	67,595	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,243	0	347,951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,281,738	0	536,208	484	0	73.00
76.00	03950	NEUROLOGY	20,834	0	10,923	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,898,143	0	3,057,085	10,540	884	88.00
91.00	09100	EMERGENCY	1,391,361	0	1,653,502	1,320	1,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	116,779	0	86,856	307	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	615,739	0	224,339	2,820	251	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,077,253	-1,379,202	13,212,743	40,156	9,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	951	117	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	487,407		1,379,202	746,706	62,191	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.022077		0.104377	18.541107	6.335676	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,632		43,029	89,704	13,904	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000391		0.003256	2.227398	1.416463	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	29,361					9.00
10.00	01000	DIETARY	164	23,310				10.00
11.00	01100	CAFETERIA	0	14,434	9,235			11.00
13.00	01300	NURSING ADMINISTRATION	186	0	193	103,034		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	84	0	2,585	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	657	0	699	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	100	2,080	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,182	8,656	2,782	57,872	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,638	0	373	7,765	1,720	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,450	0	577	0	0	54.00
60.00	06000	LABORATORY	1,523	0	643	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	11	226	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,612	0	355	7,380	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	212	4,416	0	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	1	13	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406	0	190	3,959	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,650	0	1,856	0	844	88.00
91.00	09100	EMERGENCY	1,321	0	837	17,417	21	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	165	0	92	1,906	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	222	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,244	23,090	9,235	103,034	2,585	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	220	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)	265,433	355,611	236,519	232,010	107,685	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.040326	15.255727	25.611153	2.251781	41.657640	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,619	17,390	16,925	7,498	9,124	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.225435	0.746032	1.832702	0.072772	3.529594	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/24/2018 1:28 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00591	PERSONNEL				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.05	00590	ADMINISTRATIVE & GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,519,327			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,605,114	100		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,208,975	0		50.00
53.00	05300	ANESTHESIOLOGY	476,092	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,269,027	0		54.00
60.00	06000	LABORATORY	2,911,127	0		60.00
64.00	06400	INTRAVENOUS THERAPY	910,983	0		64.00
65.00	06500	RESPIRATORY THERAPY	197,773	0		65.00
66.00	06600	PHYSICAL THERAPY	1,099,477	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	595,123	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,792	0		68.00
69.00	06900	ELECTROCARDIOLOGY	194,517	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	259,543	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,243	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,281,738	0		73.00
76.00	03950	NEUROLOGY	31,480	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3,113,644	0		88.00
91.00	09100	EMERGENCY	1,904,161	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	116,779	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	615,739	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,519,327	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	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)	449,374	111,519		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019107	1,115.190000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,204	2,281		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000731	22.810000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-2 | Date/Time Prepared: 10/24/2018 1:28 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-47,896	7.00
8.00		IV THERAPY	1	64.00	47,896	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,994,414		2,994,414	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	909,033		909,033	0	0	50.00
53.00	05300	ANESTHESIOLOGY	91,601		91,601	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,029		1,016,029	0	0	54.00
60.00	06000	LABORATORY	1,143,771		1,143,771	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	154,143		154,143	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,782	0	14,782	0	0	65.00
66.00	06600	PHYSICAL THERAPY	532,498	0	532,498	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	347,583	0	347,583	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,906	0	14,906	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,606		14,606	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,609		79,609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	397,801		397,801	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	662,198		662,198	0	0	73.00
76.00	03950	NEUROLOGY	12,664		12,664	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,797,576		3,797,576	0	0	88.00
91.00	09100	EMERGENCY	1,970,982		1,970,982	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,343		145,343		0	92.00
93.00	04950	WOUND CARE	111,985		111,985	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0		0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	319,082		319,082	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,730,606	0	14,730,606	0	0	200.00
201.00		Less Observation Beds	145,343		145,343		0	201.00
202.00		Total (see instructions)	14,585,263	0	14,585,263	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,307,046		1,307,046			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,475	2,730,012	2,731,487	0.332798	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	256,124	256,124	0.357643	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,287	3,149,204	3,242,491	0.313348	0.000000	54.00
60.00	06000	LABORATORY	223,229	2,664,893	2,888,122	0.396026	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	237,591	669,115	906,706	0.170003	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	167,269	30,422	197,691	0.074773	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	616,764	479,556	1,096,320	0.485714	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,628	136,495	595,123	0.584052	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,904	4,888	19,792	0.753133	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,016	145,165	150,181	0.097256	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200,141	59,234	259,375	0.306926	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	708,243	708,243	0.561673	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,190,588	1,086,522	2,277,110	0.290806	0.000000	73.00
76.00	03950	NEUROLOGY	0	20,834	20,834	0.607853	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	284	2,874,041	2,874,325			88.00
91.00	09100	EMERGENCY	0	1,387,630	1,387,630	1.420394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	298,068	298,068	0.487617	0.000000	92.00
93.00	04950	WOUND CARE	9,990	104,273	114,263	0.980064	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	615,739	615,739	0.518210	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,526,212	17,420,458	21,946,670			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,526,212	17,420,458	21,946,670			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	NEUROLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOUND CARE	0.000000		93.00
93.01	04951	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/24/2018 1:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,994,414		2,994,414	0	2,994,414	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	909,033		909,033	0	909,033	50.00
53.00	05300	ANESTHESIOLOGY	91,601		91,601	0	91,601	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,029		1,016,029	0	1,016,029	54.00
60.00	06000	LABORATORY	1,143,771		1,143,771	0	1,143,771	60.00
64.00	06400	INTRAVENOUS THERAPY	154,143		154,143	0	154,143	64.00
65.00	06500	RESPIRATORY THERAPY	14,782	0	14,782	0	14,782	65.00
66.00	06600	PHYSICAL THERAPY	532,498	0	532,498	0	532,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	347,583	0	347,583	0	347,583	67.00
68.00	06800	SPEECH PATHOLOGY	14,906	0	14,906	0	14,906	68.00
69.00	06900	ELECTROCARDIOLOGY	14,606		14,606	0	14,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,609		79,609	0	79,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	397,801		397,801	0	397,801	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	662,198		662,198	0	662,198	73.00
76.00	03950	NEUROLOGY	12,664		12,664	0	12,664	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,797,576		3,797,576	0	3,797,576	88.00
91.00	09100	EMERGENCY	1,970,982		1,970,982	0	1,970,982	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,343		145,343		145,343	92.00
93.00	04950	WOUND CARE	111,985		111,985	0	111,985	93.00
93.01	04951	DIABETIC EDUCATION	0		0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	319,082		319,082	0	319,082	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,730,606	0	14,730,606	0	14,730,606	200.00
201.00		Less Observation Beds	145,343		145,343		145,343	201.00
202.00		Total (see instructions)	14,585,263	0	14,585,263	0	14,585,263	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 10/24/2018 1:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,307,046		1,307,046			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,475	2,730,012	2,731,487	0.332798	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	256,124	256,124	0.357643	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,287	3,149,204	3,242,491	0.313348	0.000000	54.00
60.00	06000	LABORATORY	223,229	2,664,893	2,888,122	0.396026	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	237,591	669,115	906,706	0.170003	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	167,269	30,422	197,691	0.074773	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	616,764	479,556	1,096,320	0.485714	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,628	136,495	595,123	0.584052	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,904	4,888	19,792	0.753133	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,016	145,165	150,181	0.097256	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200,141	59,234	259,375	0.306926	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	708,243	708,243	0.561673	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,190,588	1,086,522	2,277,110	0.290806	0.000000	73.00
76.00	03950	NEUROLOGY	0	20,834	20,834	0.607853	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	284	2,874,041	2,874,325	1.321206	0.000000	88.00
91.00	09100	EMERGENCY	0	1,387,630	1,387,630	1.420394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	298,068	298,068	0.487617	0.000000	92.00
93.00	04950	WOUND CARE	9,990	104,273	114,263	0.980064	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	615,739	615,739	0.518210	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,526,212	17,420,458	21,946,670			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,526,212	17,420,458	21,946,670			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/24/2018 1:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	NEUROLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	WOUND CARE	0.000000	93.00
93.01	04951	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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 10/24/2018 1:28 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	123,273	2,731,487	0.045130	1,093	49	50.00
53.00	05300	ANESTHESIOLOGY	800	256,124	0.003123	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,639	3,242,491	0.045533	17,356	790	54.00
60.00	06000	LABORATORY	29,880	2,888,122	0.010346	41,056	425	60.00
64.00	06400	INTRAVENOUS THERAPY	1,325	906,706	0.001461	38,118	56	64.00
65.00	06500	RESPIRATORY THERAPY	978	197,691	0.004947	12,266	61	65.00
66.00	06600	PHYSICAL THERAPY	32,378	1,096,320	0.029533	5,669	167	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,600	595,123	0.012770	3,813	49	67.00
68.00	06800	SPEECH PATHOLOGY	1,350	19,792	0.068209	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,920	150,181	0.012785	1,672	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	756	259,375	0.002915	19,145	56	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,928	708,243	0.002722	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,527	2,277,110	0.004623	42,984	199	73.00
76.00	03950	NEUROLOGY	67	20,834	0.003216	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	140,170	2,874,325	0.048766	0	0	88.00
91.00	09100	EMERGENCY	30,796	1,387,630	0.022193	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,244	298,068	0.027658	0	0	92.00
93.00	04950	WOUND CARE	4,804	114,263	0.042043	106	4	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0.000000	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	544,435	20,023,885		183,278	1,877	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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	04950	WOUND CARE	0	0	0	0	0	93.00
93.01	04951	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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 10/24/2018 1:28 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	2,731,487	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	256,124	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,242,491	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	2,888,122	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	906,706	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	197,691	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,096,320	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	595,123	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	19,792	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	150,181	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	259,375	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	708,243	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,277,110	0.000000	73.00
76.00	03950	NEUROLOGY	0	0	0	20,834	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,874,325	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	1,387,630	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	298,068	0.000000	92.00
93.00	04950	WOUND CARE	0	0	0	114,263	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	20,023,885		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 10/24/2018 1:28 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	1,093	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	17,356	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	41,056	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	38,118	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	12,266	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,669	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,813	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,672	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	19,145	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	42,984	0	0	0	73.00
76.00	03950	NEUROLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
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	04950	WOUND CARE	0.000000	106	0	0	0	93.00
93.01	04951	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)		183,278	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 10/24/2018 1:28 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	0.332798	0	829,466	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.357643	0	84,942	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313348	0	808,603	0	0	54.00
60.00	06000	LABORATORY	0.396026	0	728,130	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.170003	0	263,678	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.074773	0	9,824	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485714	0	206,431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584052	0	69,314	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.753133	0	2,066	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097256	0	52,031	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.306926	0	32,035	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.561673	0	587,439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290806	0	241,532	0	0	73.00
76.00	03950	NEUROLOGY	0.607853	0	4,802	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.420394	0	398,605	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487617	0	127,270	0	0	92.00
93.00	04950	WOUND CARE	0.980064	0	96,098	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.518210		0			95.00
200.00		Subtotal (see instructions)		0	4,542,266	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	4,542,266	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 10/24/2018 1:28 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	276,045	0		50.00
53.00	05300	ANESTHESIOLOGY	30,379	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	253,374	0		54.00
60.00	06000	LABORATORY	288,358	0		60.00
64.00	06400	INTRAVENOUS THERAPY	44,826	0		64.00
65.00	06500	RESPIRATORY THERAPY	735	0		65.00
66.00	06600	PHYSICAL THERAPY	100,266	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,483	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,556	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,060	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,832	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,949	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,239	0		73.00
76.00	03950	NEUROLOGY	2,919	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	566,176	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	62,059	0		92.00
93.00	04950	WOUND CARE	94,182	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,176,438	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,176,438	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 10/24/2018 1:28 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	0.332798	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.357643	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313348	0	0	0	0	54.00
60.00	06000	LABORATORY	0.396026	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.170003	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.074773	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485714	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584052	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.753133	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097256	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.306926	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.561673	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290806	0	0	0	0	73.00
76.00	03950	NEUROLOGY	0.607853	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.420394	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487617	0	0	0	0	92.00
93.00	04950	WOUND CARE	0.980064	0	0	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.518210		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: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	NEUROLOGY	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04950	WOUND CARE	0	0	93.00
93.01	04951	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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/24/2018 1:28 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)	2,977	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	295	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)	172	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,086	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)	1,086	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	250	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)	260	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	107	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)	886	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)	886	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,994,414	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)	38,853	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)	40,407	25.00
26.00	Total swing-bed cost (see instructions)	2,645,826	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	348,588	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)	348,588	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)	1,181.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	126,438	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)	126,438	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	53,082	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	179,520	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)	1,046,951	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,046,951	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,093,902	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)	123	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,181.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	145,343	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/24/2018 1:28 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	169,853	2,994,414	0.056723	145,343	8,244	90.00
91.00	Nursing School cost	0	2,994,414	0.000000	145,343	0	91.00
92.00	Allied health cost	0	2,994,414	0.000000	145,343	0	92.00
93.00	All other Medical Education	0	2,994,414	0.000000	145,343	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 10/24/2018 1:28 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		101,968		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332798	1,093	364	50.00
53.00	05300	ANESTHESIOLOGY	0.357643	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313348	17,356	5,438	54.00
60.00	06000	LABORATORY	0.396026	41,056	16,259	60.00
64.00	06400	INTRAVENOUS THERAPY	0.170003	38,118	6,480	64.00
65.00	06500	RESPIRATORY THERAPY	0.074773	12,266	917	65.00
66.00	06600	PHYSICAL THERAPY	0.485714	5,669	2,754	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584052	3,813	2,227	67.00
68.00	06800	SPEECH PATHOLOGY	0.753133	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097256	1,672	163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.306926	19,145	5,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.561673	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290806	42,984	12,500	73.00
76.00	03950	NEUROLOGY	0.607853	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.420394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487617	0	0	92.00
93.00	04950	WOUND CARE	0.980064	106	104	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	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)		183,278	53,082	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)		183,278		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3

Component CCN: 14-Z329 | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.332798	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.357643	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313348	51,521	16,144	54.00
60.00	06000	LABORATORY	0.396026	119,683	47,398	60.00
64.00	06400	INTRAVENOUS THERAPY	0.170003	174,195	29,614	64.00
65.00	06500	RESPIRATORY THERAPY	0.074773	106,836	7,988	65.00
66.00	06600	PHYSICAL THERAPY	0.485714	459,701	223,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.584052	331,178	193,425	67.00
68.00	06800	SPEECH PATHOLOGY	0.753133	11,829	8,909	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097256	2,080	202	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.306926	128,950	39,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.561673	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290806	781,346	227,220	73.00
76.00	03950	NEUROLOGY	0.607853	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.420394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.487617	0	0	92.00
93.00	04950	WOUND CARE	0.980064	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	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)		2,167,319	793,761	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)		2,167,319		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part B Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,176,438	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,176,438	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	2,198,202	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)	12,260	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	766,197	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,419,745	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,419,745	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,419,745	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)	121,211	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	78,787	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	117,279	36.00
37.00	Subtotal (see instructions)	1,498,532	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,498,532	40.00
40.01	Sequestration adjustment (see instructions)	29,971	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,596,537	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-127,976	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 10/24/2018 1:28 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		135,744		1,642,176	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	01/11/2018	35,544	3.50
3.51			0	06/27/2018	10,095	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		-45,639	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)		135,744		1,596,537	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		1,906		127,976	6.02
7.00	Total Medicare program liability (see instructions)		133,838		1,468,561	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: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 10/24/2018 1:28 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		2,728,442		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	01/11/2018	10,020		0	3.50
3.51		06/27/2018	1,410		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)		-11,430		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)		2,717,012		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		78,059		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,795,071		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: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 10/24/2018 1:28 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: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 10/24/2018 1:28 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)	2,114,841	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)	801,699	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	1,772	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)	2,916,540	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,916,540	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)	2,916,540	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	76,168	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)	2,840,372	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)	18,063	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	11,741	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,818	0	18.00
19.00	Total (see instructions)	2,852,113	0	19.00
19.01	Sequestration adjustment (see instructions)	57,042	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,717,012	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)	78,059	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: 14-1329	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 10/24/2018 1:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	179,520	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)	179,520	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	179,520	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)	179,520	19.00
20.00	Deductibles (exclude professional component)	46,260	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	133,260	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	133,260	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,091	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,309	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,803	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	136,569	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)	136,569	30.00
30.01	Sequestration adjustment (see instructions)	2,731	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	135,744	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)	-1,906	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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 10/24/2018 1:28 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	1,880,096	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,504,860	0	0	0	4.00
5.00	Other receivable	1,114,532	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	371,937	0	0	0	7.00
8.00	Prepaid expenses	81,342	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)	6,952,767	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	439,268	0	0	0	12.00
13.00	Land improvements	431,331	0	0	0	13.00
14.00	Accumulated depreciation	-307,371	0	0	0	14.00
15.00	Buildings	9,442,661	0	0	0	15.00
16.00	Accumulated depreciation	-5,973,957	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	824,347	0	0	0	19.00
20.00	Accumulated depreciation	-500,836	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,970,233	0	0	0	23.00
24.00	Accumulated depreciation	-4,478,965	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,846,711	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	548	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	548	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,800,026	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	724,148	0	0	0	37.00
38.00	Salaries, wages, and fees payable	450,061	0	0	0	38.00
39.00	Payroll taxes payable	248,401	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,136,371	0	0	0	40.00
41.00	Deferred income	598,500	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	123,031	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,280,512	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,409,590	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)	2,409,590	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,690,102	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,109,924				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)	6,109,924	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,800,026	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 10/24/2018 1:28 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		5,043,402		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,066,522				2.00
3.00	Total (sum of line 1 and line 2)		6,109,924		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,109,924		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		6,109,924		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			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: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/24/2018 1:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	473,355		473,355	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,087,915		1,087,915	5.00
6.00	Swing bed - NF	59,896		59,896	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,621,166		1,621,166	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,621,166		1,621,166	17.00
18.00	Ancillary services	3,098,036	13,049,801	16,147,837	18.00
19.00	Outpatient services	9,990	2,010,950	2,020,940	19.00
20.00	RURAL HEALTH CLINIC	169,495	2,944,149	3,113,644	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	615,739	615,739	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,898,687	18,620,639	23,519,326	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,386,328		29.00
30.00	CHARITY CARE RHC SLIDING FEE	3,357			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)		3,357		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)		15,389,685		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 10/24/2018 1:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	23,519,326	1.00
2.00	Less contractual allowances and discounts on patients' accounts	8,513,897	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,005,429	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,389,685	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-384,256	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	29,555	6.00
7.00	Income from investments	26,275	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	187,596	24.00
24.01	COUNTY TAX REVENUE	1,140,362	24.01
24.02	STATE TAX REVENUE	90,727	24.02
24.03	ROUNDING	0	24.03
25.00	Total other income (sum of lines 6-24)	1,474,515	25.00
26.00	Total (line 5 plus line 25)	1,090,259	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	CHARITY CARE	23,737	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	23,737	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,066,522	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 10/24/2018 1:28 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	1,300,729	0	1,300,729	0	1,300,729	1.00
2.00	Physician Assistant	101,982	0	101,982	0	101,982	2.00
3.00	Nurse Practitioner	113,828	0	113,828	0	113,828	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	71,587	0	71,587	0	71,587	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	502,989	0	502,989	0	502,989	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,091,115	0	2,091,115	0	2,091,115	10.00
11.00	Physician Services Under Agreement	0	442,537	442,537	0	442,537	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	442,537	442,537	0	442,537	14.00
15.00	Medical Supplies	0	19,550	19,550	0	19,550	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	58,164	58,164	-58,164	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,714	77,714	-58,164	19,550	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,091,115	520,251	2,611,366	-58,164	2,553,202	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	26,974	26,974	0	26,974	29.00
30.00	Administrative Costs	0	66,823	66,823	158,116	224,939	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,797	93,797	158,116	251,913	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,091,115	614,048	2,705,163	99,952	2,805,115	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1

Component CCN: 14-3981 | Date/Time Prepared: 10/24/2018 1:28 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	1,300,729		1.00
2.00	Physician Assistant	0	101,982		2.00
3.00	Nurse Practitioner	-45,536	68,292		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	71,587		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	502,989		9.00
10.00	Subtotal (sum of lines 1 through 9)	-45,536	2,045,579		10.00
11.00	Physician Services Under Agreement	-7,490	435,047		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	-7,490	435,047		14.00
15.00	Medical Supplies	0	19,550		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,550		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-53,026	2,500,176		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	26,974		29.00
30.00	Administrative Costs	-31,618	193,321		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-31,618	220,295		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-84,644	2,720,471		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 10/24/2018 1:28 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	4.35	12,162	4,200	18,270		1.00
2.00	Physician Assistant	0.88	2,854	2,100	1,848		2.00
3.00	Nurse Practitioner	0.39	1,316	2,100	819		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.62	16,332		20,937	20,937	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	0.95	1,248			1,248	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)	6.57	17,580			22,185	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,500,176	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,500,176	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)					220,295	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,077,105	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,297,400	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,297,400	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,297,400	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,797,576	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 10/24/2018 1:28 pm
	Title XVIII	RHC I	Cost

			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	1.00			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	3,797,576			1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	24,945			2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	3,772,631			3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	22,185			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)	22,185			6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	170.05			7.00
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)		170.05	170.05	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,767	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	470,528	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	172	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	29,249	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	29,249	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	499,777	16.00
16.01	Total program charges (see instructions)(from contractor's records)			523,597	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,705	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,582	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.)			365,754	16.04
16.05	Total program cost (see instructions)		0	368,336	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			40,002	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			96,157	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			368,336	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,066	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			371,402	22.00
23.00	Allowable bad debts (see instructions)			24,551	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			15,958	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			23,557	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)			387,360	26.00
26.01	Sequestration adjustment (see instructions)			7,747	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			342,531	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)			37,082	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: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 10/24/2018 1:28 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,045,579	2,045,579	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000268	0.000790	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	548	1,616	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	9,957	4,301	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	10,505	5,917	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,500,176	2,500,176	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,297,400	1,297,400	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004202	0.002367	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,452	3,071	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,957	8,988	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	62	183	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	257.37	49.11	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,544	1,522	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)		24,945	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)		3,066	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 10/24/2018 1:28 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		358,386	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		01/11/2018	11,713	3.50
3.51		06/27/2018	4,142	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)		-15,855	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		342,531	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		37,082	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		379,613	7.00

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