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: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 2:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2019 Time: 2:36 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 FAYETTE COUNTY HOSPITAL (14-1346) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GREG STARNES
Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-226,079	214,473	0	-57,296	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	121,629	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		6,143		0	10.00
10.01	RURAL HEALTH CLINIC II	0		4,106		0	10.01
200.00	Total	0	-104,450	224,722	0	-57,296	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 2:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SEVENTH & TAYLOR	PO Box:			1.00
2.00	City: VANDALIA	State: IL	Zip Code: 62471-	County: FAYETTE	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	FAYETTE COUNTY HOSPITAL	141346	99914	1	04/01/2005	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	FAYETTE COUNTY SNF	14Z346	99914		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAYETTE COUNTY SNF	145499	99914		07/01/1983	N	P	O	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	VANDALIA	148527	99914		06/01/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	ST ELMO	148528	99914		06/01/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 2:36 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 2:36 pm

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

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 2:36 pm

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

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 2:36 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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	Y	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	N	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	N	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	Y	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	Y	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	N	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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 2:36 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	130,265	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	44.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2019 2:36 pm

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

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

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

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

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

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

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

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

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

		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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2019 2:36 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	03/13/2019	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	03/20/2019	Y	03/20/2019	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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 2:36 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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	SHAWN		ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & COMPANY LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500		SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 2:36 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.	SENIOR 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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 2:36 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	7,665	37,944.00	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	7,665	37,944.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	1,344.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		29	9,125	39,288.00	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	44.00	85	31,025		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		114				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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 2:36 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)	1,132	115	1,581			1.00
2.00	HMO and other (see instructions)	0	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	1,232	0	1,232			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	292			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,364	115	3,105			7.00
8.00	INTENSIVE CARE UNIT	33	0	56			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)	2,397	115	3,161	0.00	175.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	340	7,088	17,911	0.00	31.96	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			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,634	0	7,476	0.00	8.62	26.00
26.01	RURAL HEALTH CLINIC II	381	0	1,254	0.00	2.21	26.01
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	218.54	27.00
28.00	Observation Bed Days		0	412			28.00
29.00	Ambulance Trips	313					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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2019 2:36 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	339	37	489	1.00
2.00	HMO and other (see instructions)			0	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	339	37	489	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 2:36 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/01/2005	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	3	0	3	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	14	0	14	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	56	0	56	15.00
16.00		RVB	12	0	12	16.00
17.00		RVA	14	0	14	17.00
18.00		RHC	89	0	89	18.00
19.00		RHB	30	0	30	19.00
20.00		RHA	36	0	36	20.00
21.00		RMC	43	0	43	21.00
22.00		RMB	8	0	8	22.00
23.00		RMA	12	0	12	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	13	0	13	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	6	0	6	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	4	0	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-7 | Date/Time Prepared: 5/28/2019 2:36 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		340	0	340	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	COL 7 WKST A	1,281,950	41.90	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,059,518			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1442 N 8TH STREET, SUITE C		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	VANDALIA		IL	62471	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:00	07:00	11.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FAYETTE				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	17:00	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/28/2019 2:36 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	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			428 N MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SAINT ELMO		IL	62458	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	12:00	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		FAYETTE				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	12:00	13:00	17:00	08:00	12:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1346
Component CCN: 14-8528

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

Worksheet S-8
Date/Time Prepared:
5/28/2019 2:36 pm

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/28/2019 2:36 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)	0.351886	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,164,837	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,066,777	5.00
6.00	Medicaid charges	13,451,361	6.00
7.00	Medicaid cost (line 1 times line 6)	4,733,346	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	373,369	0	373,369	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	131,383	0	131,383	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	131,383	0	131,383	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,878,978	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	655,937	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,009,134	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,869,844	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,011,169	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,142,552	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,142,552	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		139,630	139,630	52,542	192,172	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		537,946	537,946	22,818	560,764	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,980	3,238,475	3,401,455	9,902	3,411,357	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	992,238	3,949,846	4,942,084	144,840	5,086,924	5.00
7.00	00700	OPERATION OF PLANT	261,918	78,859	340,777	18,635	359,412	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	608,992	608,992	0	608,992	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,835	12,835	0	12,835	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	88,003	43,009	131,012	0	131,012	8.00
9.00	00900	HOUSEKEEPING	393,301	110,830	504,131	0	504,131	9.00
10.00	01000	DIETARY	330,545	391,113	721,658	-269,724	451,934	10.00
11.00	01100	CAFETERIA	0	0	0	269,724	269,724	11.00
13.00	01300	NURSING ADMINISTRATION	129,385	17,268	146,653	0	146,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	55,050	626,721	681,771	-544,793	136,978	14.00
15.00	01500	PHARMACY	199,151	1,624,061	1,823,212	-1,217,622	605,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	298,954	212,697	511,651	0	511,651	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	274,700	274,700	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,085,962	230,226	1,316,188	-82,057	1,234,131	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	40,554	40,554	31.00
44.00	04400	SKILLED NURSING FACILITY	1,239,020	436,472	1,675,492	0	1,675,492	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	602,692	549,517	1,152,209	-317,860	834,349	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,596	878,686	1,307,282	-1,962	1,305,320	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	135,400	135,400	-1,106	134,294	55.00
60.00	06000	LABORATORY	606,493	872,023	1,478,516	-194	1,478,322	60.00
65.00	06500	RESPIRATORY THERAPY	150,271	102,226	252,497	-25,640	226,857	65.00
66.00	06600	PHYSICAL THERAPY	465,651	49,036	514,687	-569	514,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,620	6,205	75,825	0	75,825	67.00
68.00	06800	SPEECH PATHOLOGY	18,463	1,179	19,642	0	19,642	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	458,518	458,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	218,982	218,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,246,156	1,246,156	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	786,240	119,849	906,089	1,152	907,241	88.00
88.01	08801	RURAL HEALTH CLINIC II	109,288	67,612	176,900	-1,152	175,748	88.01
90.00	09000	CLINIC	0	597,520	597,520	0	597,520	90.00
90.01	09002	WOUND CARE	24,368	222,560	246,928	0	246,928	90.01
90.02	09003	PAIN MANAGEMENT	0	166,180	166,180	0	166,180	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	377,037	22,522	399,559	50,289	449,848	90.04
90.05	09005	DR BLASER	463,211	33,446	496,657	9,694	506,351	90.05
90.06	09006	DR. RONHOLM	0	86,473	86,473	42,413	128,886	90.06
90.07	09007	DR. BARKOVIAK	0	99,000	99,000	82,463	181,463	90.07
90.08	04950	NP LANGSTON	0	0	0	78,685	78,685	90.08
91.00	09100	EMERGENCY	853,261	1,908,692	2,761,953	263,712	3,025,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	358,830	59,244	418,074	-303,519	114,555	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,550,528	18,236,350	28,786,878	519,581	29,306,459	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,247,960	233,979	1,481,939	-280,291	1,201,648	192.00
192.01	19201	FAYETTE COUNTY ANNEX	118,703	120,587	239,290	-239,290	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	11,917,191	18,590,916	30,508,107	0	30,508,107	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,033,310	1,225,482		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-199,807	360,957		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-14,996	3,396,361		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,147,926	3,938,998		5.00
7.00	00700	OPERATION OF PLANT	-974	358,438		7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	608,992		7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,835		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,012		8.00
9.00	00900	HOUSEKEEPING	0	504,131		9.00
10.00	01000	DIETARY	0	451,934		10.00
11.00	01100	CAFETERIA	-86,558	183,166		11.00
13.00	01300	NURSING ADMINISTRATION	0	146,653		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	136,978		14.00
15.00	01500	PHARMACY	-326,686	278,904		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4	511,647		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-274,700	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-124,377	1,109,754		30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,554		31.00
44.00	04400	SKILLED NURSING FACILITY	-644,187	1,031,305		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	834,349		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-753	1,304,567		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	134,294		55.00
60.00	06000	LABORATORY	0	1,478,322		60.00
65.00	06500	RESPIRATORY THERAPY	-23,016	203,841		65.00
66.00	06600	PHYSICAL THERAPY	0	514,118		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,825		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,642		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	458,518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	218,982		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,246,156		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-210	907,031		88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,885	172,863		88.01
90.00	09000	CLINIC	0	597,520		90.00
90.01	09002	WOUND CARE	-30,062	216,866		90.01
90.02	09003	PAIN MANAGEMENT	-166,002	178		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	-306,787	143,061		90.04
90.05	09005	DR BLASER	-467,650	38,701		90.05
90.06	09006	DR. RONHOLM	-86,185	42,701		90.06
90.07	09007	DR. BARKOVIAK	-99,006	82,457		90.07
90.08	04950	NP LANGSTON	-77,466	1,219		90.08
91.00	09100	EMERGENCY	-1,133,263	1,892,402		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	114,555		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,180,190	25,126,269		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,201,648		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	0		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,180,190	26,327,917		200.00

RECLASSIFICATIONS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 2:36 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	123,543	146,181		1.00
	0		123,543	146,181		
	B - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	274,700		1.00
	0		0	274,700		
	C - EMERGENCY ROOM					
1.00	EMERGENCY	91.00	301,417	0		1.00
	0		301,417	0		
	D - AUTO INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	22,818		1.00
	0		0	22,818		
	E - OCCUPATIONAL HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13,594	3,153		1.00
	0		13,594	3,153		
	F - WELLNESS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	75,360		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	118,703	26,137		2.00
3.00	OPERATION OF PLANT	7.00	0	18,635		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	453		5.00
	0		118,703	120,587		
	G - MEDICAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	677,498		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	677,498		
	H - SCU					
1.00	INTENSIVE CARE UNIT	31.00	34,397	6,157		1.00
	0		34,397	6,157		
	I - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,245,703		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	1,245,703		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	218,982		1.00
	0		0	218,982		
	M - RHC TRAVEL EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	1,152		1.00
	0		0	1,152		
	O - SPECIALTY CLINIC RECLASS					
1.00	DR SKOW	90.04	42,918	7,371		1.00
2.00	DR BLASER	90.05	8,273	1,421		2.00
3.00	DR. RONHOLM	90.06	36,196	6,217		3.00
4.00	DR. BARKOVIAK	90.07	70,376	12,087		4.00
	0		157,763	27,096		
	P - PROVIDER BASED RECLASS					
1.00	NP LANGSTON	90.08	77,466	1,219		1.00
	TOTALS		77,466	1,219		
500.00	Grand Total: Increases		826,883	2,745,246		500.00

RECLASSIFICATIONS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/28/2019 2:36 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	123,543	146,181	0	1.00
	0		123,543	146,181		
	B - CRNA					
1.00	OPERATING ROOM	50.00	0	274,700	0	1.00
	0		0	274,700		
	C - EMERGENCY ROOM					
1.00	AMBULANCE SERVICES	95.00	301,417	0	0	1.00
	0		301,417	0		
	D - AUTO INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	22,818	12	1.00
	0		0	22,818		
	E - OCCUPATIONAL HEALTH					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	13,594	3,153	0	1.00
	0		13,594	3,153		
	F - WELLNESS					
1.00	FAYETTE COUNTY ANNEX	192.01	118,703	120,587	9	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
5.00		0.00	0	0	0	5.00
	0		118,703	120,587		
	G - MEDICAL SUPPLY					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	544,793	0	1.00
2.00	PHARMACY	15.00	0	1,320	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	29,733	0	3.00
4.00	OPERATING ROOM	50.00	0	41,172	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	822	0	5.00
6.00	LABORATORY	60.00	0	194	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	25,626	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	569	0	8.00
9.00	EMERGENCY	91.00	0	32,532	0	9.00
10.00	AMBULANCE SERVICES	95.00	0	737	0	10.00
	0		0	677,498		
	H - SCU					
1.00	ADULTS & PEDIATRICS	30.00	34,397	6,157	0	1.00
	0		34,397	6,157		
	I - DRUGS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,845	0	1.00
2.00	PHARMACY	15.00	0	1,216,302	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	11,770	0	3.00
4.00	OPERATING ROOM	50.00	0	1,988	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,140	0	5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,106	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	14	0	7.00
8.00	EMERGENCY	91.00	0	5,173	0	8.00
9.00	AMBULANCE SERVICES	95.00	0	1,365	0	9.00
	0		0	1,245,703		
	K - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	218,982	0	1.00
	0		0	218,982		
	M - RHC TRAVEL EXPENSE					
1.00	RURAL HEALTH CLINIC II	88.01	0	1,152	0	1.00
	0		0	1,152		
	O - SPECIALTY CLINIC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	157,763	27,096	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		157,763	27,096		
	P - PROVIDER BASED RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	77,466	1,219	0	1.00
	TOTALS		77,466	1,219		
500.00	Grand Total: Decreases		826,883	2,745,246		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,233,831	211,867	0	211,867	0	6.00
7.00	HIT designated Assets	1,898,111	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,131,942	211,867	0	211,867	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,131,942	211,867	0	211,867	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,445,698	0	6.00
7.00	HIT designated Assets	1,898,111	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,343,809	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	8,343,809	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2019 2:36 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	139,630	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	537,946	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	537,946	0	0	139,630	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	139,630	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	537,946	2.00
3.00	Total (sum of lines 1-2)	0	677,576	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 2:36 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,343,809	0	8,343,809	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	8,343,809	0	8,343,809	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,108,670	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	338,139	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,446,809	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	NEW CAP REL COSTS-BLDG & FIXT	0	116,812	0	0	1,225,482	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	22,818	0	0	360,957	2.00
3.00	Total (sum of lines 1-2)	0	139,630	0	0	1,586,439	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 2:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-68,242	ADMINISTRATIVE & GENERAL	5.00	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	-1,562	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,433,136			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	11,812			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-86,558	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-974	OPERATION OF PLANT	7.00	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-274,700	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/28/2019 2:36 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	-199,807	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC EMPLOYEE BENEFIT REVENUE	B	-880	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC OTHER NON OPERATING INCOME	B	-1,204	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RADIOLOGY MISC INCOME	B	-755	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	DR FUNNEMAN MISC REVENUE	B	-210	RURAL HEALTH CLINIC	88.00	0	33.03
33.04	PA BRUCE MISC REVENUE	B	-2,885	RURAL HEALTH CLINIC II	88.01	0	33.04
33.07	PAIN MANAGEMENT MISC REVENUE	B	-2	PAIN MANAGEMENT	90.02	0	33.07
34.00	DR SKOW MISC REVENUE	B	-3,106	DR SKOW	90.04	0	34.00
34.01	DR BLASER MISC REVENUE	B	-80	DR BLASER	90.05	0	34.01
34.02	DR. BARKOVIAK MISC REVENUE	B	-6	DR. BARKOVIAK	90.07	0	34.02
34.03	ER MISC REVENUE	B	-18	EMERGENCY	91.00	0	34.03
34.04	MARKETING EXPENSE	A	-43,277	ADMINISTRATIVE & GENERAL	5.00	0	34.04
34.05	AHA LOBBYING DUES PERCENTAGE	A	-3,111	ADMINISTRATIVE & GENERAL	5.00	0	34.05
34.06	IHA LOBBYING DUES PERCENTAGE	A	-9,030	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	340B EXPENSE OFFSET	A	-326,686	PHARMACY	15.00	0	34.07
34.08	LTC MEDCAID ASSESSMENT	A	-152,187	SKILLED NURSING FACILITY	44.00	0	34.08
34.09	OTHER INCOME - SNF TAX REVENUE	B	-492,000	SKILLED NURSING FACILITY	44.00	0	34.09
34.10	NURSE PRACTITIONER SALARY	A	-77,466	NP LANGSTON	90.08	0	34.10
34.11	NURSE PRACTITIONER BENEFITS	A	-14,116	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,180,190				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 2:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY DIAGNOSTIC - DSS M	218,736	218,734	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	BLUE BENEFITS CONSULTING	7,340	7,340	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	BLUE & COMPANY LLC	59,664	59,664	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	684,605	684,605	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,020	7,020	3.02
4.00	5.00	ADMINISTRATIVE & GENERAL	HEARTLAND ST ELMO	33,850	33,850	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	FAYETTE COUNTY DISTRICT	0	1,021,500	4.01
4.02	1.00	NEW CAP REL COSTS-BLDG & FIX	FAYETTE COUNTY DISTRICT	1,033,310	0	4.02
4.03	0.00			0	0	4.03
5.00	0		0	2,044,525	2,032,713	5.00

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

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

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

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

6.00	B	ALLIANT MGT	100.00		0.00	6.00
7.00	B	BLUEGRASS LEAS	100.00		0.00	7.00
8.00	B	ALLIANT PURCH	100.00		0.00	8.00
9.00	B	HEARTLAND STELM	100.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2019 2:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
4.00	0	0		4.00
4.01	-1,021,500	0		4.01
4.02	1,033,310	9		4.02
4.03	0	9		4.03
5.00	11,812			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2019 2:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	138,513	124,377	14,136	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	8,000	0	8,000	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	25,500	23,016	2,484	0	0	3.00
4.00	90.01	WOUND CARE	30,062	30,062	0	0	0	4.00
5.00	90.02	PAIN MANAGEMENT	166,180	166,000	180	0	0	5.00
6.00	90.04	DR SKOW	340,690	303,681	37,009	0	0	6.00
7.00	90.05	DR BLASER	475,589	467,570	8,019	0	0	7.00
8.00	90.06	DR. RONHOLM	86,185	86,185	0	0	0	8.00
9.00	90.07	DR. BARKOVIAK	99,000	99,000	0	0	0	9.00
10.00	91.00	EMERGENCY	1,743,454	1,133,245	610,209	0	0	10.00
200.00			3,113,173	2,433,136	680,037		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.01	WOUND CARE	0	0	0	0	0	4.00
5.00	90.02	PAIN MANAGEMENT	0	0	0	0	0	5.00
6.00	90.04	DR SKOW	0	0	0	0	0	6.00
7.00	90.05	DR BLASER	0	0	0	0	0	7.00
8.00	90.06	DR. RONHOLM	0	0	0	0	0	8.00
9.00	90.07	DR. BARKOVIAK	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	124,377		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	23,016		3.00
4.00	90.01	WOUND CARE	0	0	0	30,062		4.00
5.00	90.02	PAIN MANAGEMENT	0	0	0	166,000		5.00
6.00	90.04	DR SKOW	0	0	0	303,681		6.00
7.00	90.05	DR BLASER	0	0	0	467,570		7.00
8.00	90.06	DR. RONHOLM	0	0	0	86,185		8.00
9.00	90.07	DR. BARKOVIAK	0	0	0	99,000		9.00
10.00	91.00	EMERGENCY	0	0	0	1,133,245		10.00
200.00			0	0	0	2,433,136		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,225,482	1,225,482				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	360,957		360,957			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,396,361	5,302	719	3,402,382		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,938,998	71,763	189,298	345,873	4,545,932	5.00
7.00	00700	OPERATION OF PLANT	358,438	393,613	5,800	81,544	839,395	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	608,992	0	0	0	608,992	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	12,835	0	0	0	12,835	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	131,012	21,021	0	27,398	179,431	8.00
9.00	00900	HOUSEKEEPING	504,131	6,319	0	122,448	632,898	9.00
10.00	01000	DIETARY	451,934	34,565	3,916	64,447	554,862	10.00
11.00	01100	CAFETERIA	183,166	0	0	38,463	221,629	11.00
13.00	01300	NURSING ADMINISTRATION	146,653	13,927	0	40,282	200,862	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	136,978	8,410	0	17,139	162,527	14.00
15.00	01500	PHARMACY	278,904	0	0	62,002	340,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	511,647	20,946	0	93,074	625,667	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,109,754	65,985	559	327,387	1,503,685	30.00
31.00	03100	INTENSIVE CARE UNIT	40,554	7,346	0	10,709	58,609	31.00
44.00	04400	SKILLED NURSING FACILITY	1,031,305	246,465	4,331	385,744	1,667,845	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	834,349	44,926	95,336	187,638	1,162,249	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304,567	32,428	8,775	133,436	1,479,206	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	134,294	0	0	0	134,294	55.00
60.00	06000	LABORATORY	1,478,322	46,149	35,758	188,821	1,749,050	60.00
65.00	06500	RESPIRATORY THERAPY	203,841	8,438	2,970	46,784	262,033	65.00
66.00	06600	PHYSICAL THERAPY	514,118	19,481	0	144,973	678,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,825	1,587	0	21,675	99,087	67.00
68.00	06800	SPEECH PATHOLOGY	19,642	0	0	5,748	25,390	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	458,518	0	0	0	458,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,982	0	0	0	218,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,246,156	0	0	0	1,246,156	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	907,031	0	0	244,782	1,151,813	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,863	0	0	34,025	206,888	88.01
90.00	09000	CLINIC	597,520	64,136	998	0	662,654	90.00
90.01	09002	WOUND CARE	216,866	2,044	0	7,587	226,497	90.01
90.02	09003	PAIN MANAGEMENT	178	2,044	0	0	2,222	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	143,061	4,957	0	24,678	172,696	90.04
90.05	09005	DR BLASER	38,701	9,605	0	0	48,306	90.05
90.06	09006	DR. RONHOLM	42,701	2,044	0	11,269	56,014	90.06
90.07	09007	DR. BARKOVIAK	82,457	2,044	0	21,910	106,411	90.07
90.08	04950	NP LANGSTON	1,219	3,108	0	24,118	28,445	90.08
91.00	09100	EMERGENCY	1,892,402	26,314	926	359,489	2,279,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	114,555	0	1,479	17,875	133,909	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,126,269	1,164,967	350,865	3,091,318	24,744,598	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,293	0	0	5,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,201,648	55,222	10,092	311,064	1,578,026	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
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)	26,327,917	1,225,482	360,957	3,402,382	26,327,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,545,932					5.00
7.00	00700	OPERATION OF PLANT	175,183	1,014,578				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	127,097	0	736,089			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	2,679	0	0	15,514		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	37,447	28,256	22,403	0	267,537	8.00
9.00	00900	HOUSEKEEPING	132,086	8,494	6,735	0	19,372	9.00
10.00	01000	DIETARY	115,800	46,461	36,838	0	2,905	10.00
11.00	01100	CAFETERIA	46,254	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	41,920	18,720	14,843	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,920	11,305	8,963	0	0	14.00
15.00	01500	PHARMACY	71,147	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,577	28,155	22,324	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	313,821	88,694	70,324	0	40,015	30.00
31.00	03100	INTENSIVE CARE UNIT	12,232	9,874	7,829	0	14	31.00
44.00	04400	SKILLED NURSING FACILITY	348,081	331,287	262,671	0	130,702	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	242,563	60,388	47,881	0	14,339	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,712	43,588	34,560	0	2,651	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	28,027	0	0	0	0	55.00
60.00	06000	LABORATORY	365,028	62,032	49,184	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	54,687	11,342	8,993	0	56	65.00
66.00	06600	PHYSICAL THERAPY	141,619	26,185	20,762	0	11,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,680	2,133	1,691	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,299	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,693	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,702	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,074	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	240,385	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	43,178	0	0	0	0	88.01
90.00	09000	CLINIC	138,297	86,210	0	15,514	0	90.00
90.01	09002	WOUND CARE	47,270	2,748	2,179	0	0	90.01
90.02	09003	PAIN MANAGEMENT	464	2,748	2,179	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	36,042	6,662	5,283	0	0	90.04
90.05	09005	DR BLASER	10,082	12,911	10,237	0	0	90.05
90.06	09006	DR. RONHOLM	11,690	2,748	2,179	0	0	90.06
90.07	09007	DR. BARKOVIAK	22,208	2,748	2,179	0	0	90.07
90.08	04950	NP LANGSTON	5,936	4,178	3,313	0	0	90.08
91.00	09100	EMERGENCY	475,664	35,370	28,044	0	22,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	27,947	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,215,491	933,237	671,594	15,514	243,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,105	7,114	5,641	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	329,336	74,227	58,854	0	142	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	90	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	23,598	192.03
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)	4,545,932	1,014,578	736,089	15,514	267,537	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	799,585					9.00
10.00	01000	DIETARY	37,992	794,858				10.00
11.00	01100	CAFETERIA	0	0	267,883			11.00
13.00	01300	NURSING ADMINISTRATION	15,308	0	3,567	295,220		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,244	0	4,335	0	230,294	14.00
15.00	01500	PHARMACY	0	0	5,238	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,023	0	13,366	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,526	122,069	37,953	112,049	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,074	1,198	1,309	3,866	0	31.00
44.00	04400	SKILLED NURSING FACILITY	270,900	628,274	74,144	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,380	0	19,078	56,324	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,642	0	17,701	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	50,724	0	27,703	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,275	0	6,344	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,412	0	13,276	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,744	0	1,784	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	429	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	155,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	74,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	70,495	43,317	0	0	0	90.00
90.01	09002	WOUND CARE	2,247	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	2,247	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	5,448	0	0	0	0	90.04
90.05	09005	DR BLASER	10,557	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	2,247	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	2,247	0	0	0	0	90.07
90.08	04950	NP LANGSTON	3,417	0	0	0	0	90.08
91.00	09100	EMERGENCY	28,922	0	39,082	115,382	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,574	7,599	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	733,071	794,858	267,883	295,220	230,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,817	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,697	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
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)	799,585	794,858	267,883	295,220	230,294	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
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
15.00	01500	PHARMACY	417,291					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	843,112				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	49,824	0	2,410,960	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,329	0	104,334	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	37,543	0	3,751,447	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,549	0	1,685,751	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,745	0	2,093,805	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,609	0	169,930	0	55.00
60.00	06000	LABORATORY	0	183,993	0	2,487,714	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,006	0	377,736	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,770	0	939,219	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,994	0	131,113	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	580	0	31,698	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,902	0	737,971	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,300	0	351,420	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	417,291	94,664	0	2,018,185	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,139	0	1,405,337	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,195	0	252,261	0	88.01
90.00	09000	CLINIC	0	25,732	0	1,042,219	0	90.00
90.01	09002	WOUND CARE	0	10,220	0	291,161	0	90.01
90.02	09003	PAIN MANAGEMENT	0	531	0	10,391	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	1,244	0	227,375	0	90.04
90.05	09005	DR BLASER	0	2,465	0	94,558	0	90.05
90.06	09006	DR. RONHOLM	0	793	0	75,671	0	90.06
90.07	09007	DR. BARKOVIAK	0	871	0	136,664	0	90.07
90.08	04950	NP LANGSTON	0	1,300	0	46,589	0	90.08
91.00	09100	EMERGENCY	0	94,076	0	3,117,701	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	14,738	0	186,767	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	417,291	843,112	0	24,177,977	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	24,970	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,101,282	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	90	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	23,598	0	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	417,291	843,112	0	26,327,917	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,410,960		30.00
31.00	03100	INTENSIVE CARE UNIT	104,334		31.00
44.00	04400	SKILLED NURSING FACILITY	3,751,447		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,685,751		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,093,805		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,930		55.00
60.00	06000	LABORATORY	2,487,714		60.00
65.00	06500	RESPIRATORY THERAPY	377,736		65.00
66.00	06600	PHYSICAL THERAPY	939,219		66.00
67.00	06700	OCCUPATIONAL THERAPY	131,113		67.00
68.00	06800	SPEECH PATHOLOGY	31,698		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	737,971		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	351,420		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,185		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,405,337		88.00
88.01	08801	RURAL HEALTH CLINIC II	252,261		88.01
90.00	09000	CLINIC	1,042,219		90.00
90.01	09002	WOUND CARE	291,161		90.01
90.02	09003	PAIN MANAGEMENT	10,391		90.02
90.03	09001	NEUROLOGY	0		90.03
90.04	09004	DR SKOW	227,375		90.04
90.05	09005	DR BLASER	94,558		90.05
90.06	09006	DR. RONHOLM	75,671		90.06
90.07	09007	DR. BARKOVIAK	136,664		90.07
90.08	04950	NP LANGSTON	46,589		90.08
91.00	09100	EMERGENCY	3,117,701		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	186,767		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,177,977		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,970		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,101,282		192.00
192.01	19201	FAYETTE COUNTY ANNEX	90		192.01
192.02	19202	PUBLIC RELATIONS	0		192.02
192.03	19203	PERSONAL LAUNDRY	23,598		192.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	26,327,917		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,302	719	6,021	6,021	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	71,763	189,298	261,061	612	5.00
7.00	00700	OPERATION OF PLANT	0	393,613	5,800	399,413	144	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,021	0	21,021	48	8.00
9.00	00900	HOUSEKEEPING	0	6,319	0	6,319	217	9.00
10.00	01000	DIETARY	0	34,565	3,916	38,481	114	10.00
11.00	01100	CAFETERIA	0	0	0	0	68	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,927	0	13,927	71	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,410	0	8,410	30	14.00
15.00	01500	PHARMACY	0	0	0	0	110	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,946	0	20,946	165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	65,985	559	66,544	579	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,346	0	7,346	19	31.00
44.00	04400	SKILLED NURSING FACILITY	0	246,465	4,331	250,796	683	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,926	95,336	140,262	332	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,428	8,775	41,203	236	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	46,149	35,758	81,907	334	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,438	2,970	11,408	83	65.00
66.00	06600	PHYSICAL THERAPY	0	19,481	0	19,481	257	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,587	0	1,587	38	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	10	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	433	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	60	88.01
90.00	09000	CLINIC	0	64,136	998	65,134	0	90.00
90.01	09002	WOUND CARE	0	2,044	0	2,044	13	90.01
90.02	09003	PAIN MANAGEMENT	0	2,044	0	2,044	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	4,957	0	4,957	44	90.04
90.05	09005	DR BLASER	0	9,605	0	9,605	0	90.05
90.06	09006	DR. RONHOLM	0	2,044	0	2,044	20	90.06
90.07	09007	DR. BARKOVIAK	0	2,044	0	2,044	39	90.07
90.08	04950	NP LANGSTON	0	3,108	0	3,108	43	90.08
91.00	09100	EMERGENCY	0	26,314	926	27,240	636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,479	1,479	32	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,164,967	350,865	1,515,832	5,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,293	0	5,293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,222	10,092	65,314	551	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,225,482	360,957	1,586,439	6,021	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	261,673					5.00
7.00	00700	OPERATION OF PLANT	10,084	409,641				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	7,316	0	7,316			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	154	0	0	154		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,156	11,408	223	0	34,856	8.00
9.00	00900	HOUSEKEEPING	7,603	3,430	67	0	2,524	9.00
10.00	01000	DIETARY	6,666	18,759	366	0	378	10.00
11.00	01100	CAFETERIA	2,662	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,413	7,558	148	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,952	4,564	89	0	0	14.00
15.00	01500	PHARMACY	4,095	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,516	11,368	222	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,064	35,811	699	0	5,213	30.00
31.00	03100	INTENSIVE CARE UNIT	704	3,987	78	0	2	31.00
44.00	04400	SKILLED NURSING FACILITY	20,036	133,759	2,608	0	17,030	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,962	24,382	476	0	1,868	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,770	17,599	343	0	345	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,613	0	0	0	0	55.00
60.00	06000	LABORATORY	21,011	25,046	489	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,148	4,580	89	0	7	65.00
66.00	06600	PHYSICAL THERAPY	8,152	10,572	206	0	1,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,190	861	17	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	305	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,508	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,631	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,970	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,837	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,485	0	0	0	0	88.01
90.00	09000	CLINIC	7,960	34,808	0	154	0	90.00
90.01	09002	WOUND CARE	2,721	1,109	22	0	0	90.01
90.02	09003	PAIN MANAGEMENT	27	1,109	22	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	2,075	2,690	53	0	0	90.04
90.05	09005	DR BLASER	580	5,213	102	0	0	90.05
90.06	09006	DR. RONHOLM	673	1,109	22	0	0	90.06
90.07	09007	DR. BARKOVIAK	1,278	1,109	22	0	0	90.07
90.08	04950	NP LANGSTON	342	1,687	33	0	0	90.08
91.00	09100	EMERGENCY	27,384	14,281	279	0	2,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,609	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,652	376,799	6,675	154	31,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64	2,872	56	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,957	29,970	585	0	19	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	12	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	3,074	192.03
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)	261,673	409,641	7,316	154	34,856	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	20,160					9.00
10.00	01000	DIETARY	958	65,722				10.00
11.00	01100	CAFETERIA	0	0	2,730			11.00
13.00	01300	NURSING ADMINISTRATION	386	0	36	24,539		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233	0	44	0	15,322	14.00
15.00	01500	PHARMACY	0	0	53	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	580	0	136	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,829	10,093	387	9,314	0	30.00
31.00	03100	INTENSIVE CARE UNIT	204	99	13	321	0	31.00
44.00	04400	SKILLED NURSING FACILITY	6,829	51,948	759	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,245	0	194	4,682	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899	0	180	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,279	0	282	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	234	0	65	0	0	65.00
66.00	06600	PHYSICAL THERAPY	540	0	135	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	44	0	18	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	1,777	3,582	0	0	0	90.00
90.01	09002	WOUND CARE	57	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	57	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	137	0	0	0	0	90.04
90.05	09005	DR BLASER	266	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	57	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	57	0	0	0	0	90.07
90.08	04950	NP LANGSTON	86	0	0	0	0	90.08
91.00	09100	EMERGENCY	729	0	398	9,590	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	26	632	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,483	65,722	2,730	24,539	15,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	147	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,530	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
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)	20,160	65,722	2,730	24,539	15,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
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
15.00	01500	PHARMACY	4,258					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,933				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,420		150,953	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	65		12,838	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,823		486,271	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,629		189,032	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,342		86,917	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	370		1,983	0	55.00
60.00	06000	LABORATORY	0	8,920		139,268	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,215		20,829	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,252		42,109	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	194		3,949	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	28		347	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,355		17,233	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	597		8,180	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,258	4,598		23,826	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	638		14,908	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	107		2,652	0	88.01
90.00	09000	CLINIC	0	1,250		114,665	0	90.00
90.01	09002	WOUND CARE	0	496		6,462	0	90.01
90.02	09003	PAIN MANAGEMENT	0	26		3,285	0	90.02
90.03	09001	NEUROLOGY	0	0		0	0	90.03
90.04	09004	DR SKOW	0	60		10,016	0	90.04
90.05	09005	DR BLASER	0	120		15,886	0	90.05
90.06	09006	DR. RONHOLM	0	38		3,963	0	90.06
90.07	09007	DR. BARKOVIAK	0	42		4,591	0	90.07
90.08	04950	NP LANGSTON	0	63		5,362	0	90.08
91.00	09100	EMERGENCY	0	4,569		87,976	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	716		4,494	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,258	40,933	0	1,457,995	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		8,432	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		116,926	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		12	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0		0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0		3,074	0	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,258	40,933	0	1,586,439	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	150,953		30.00
31.00	03100	INTENSIVE CARE UNIT	12,838		31.00
44.00	04400	SKILLED NURSING FACILITY	486,271		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	189,032		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,917		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,983		55.00
60.00	06000	LABORATORY	139,268		60.00
65.00	06500	RESPIRATORY THERAPY	20,829		65.00
66.00	06600	PHYSICAL THERAPY	42,109		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,949		67.00
68.00	06800	SPEECH PATHOLOGY	347		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,233		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,180		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,826		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	14,908		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,652		88.01
90.00	09000	CLINIC	114,665		90.00
90.01	09002	WOUND CARE	6,462		90.01
90.02	09003	PAIN MANAGEMENT	3,285		90.02
90.03	09001	NEUROLOGY	0		90.03
90.04	09004	DR SKOW	10,016		90.04
90.05	09005	DR BLASER	15,886		90.05
90.06	09006	DR. RONHOLM	3,963		90.06
90.07	09007	DR. BARKOVIAK	4,591		90.07
90.08	04950	NP LANGSTON	5,362		90.08
91.00	09100	EMERGENCY	87,976		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	4,494		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,457,995		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,432		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,926		192.00
192.01	19201	FAYETTE COUNTY ANNEX	12		192.01
192.02	19202	PUBLIC RELATIONS	0		192.02
192.03	19203	PERSONAL LAUNDRY	3,074		192.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,586,439		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	131,287					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		535,561				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	568	1,067	10,928,443			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,688	280,862	1,110,941	-4,545,932	21,781,985	5.00
7.00	00700	OPERATION OF PLANT	42,168	8,606	261,918	0	839,395	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	608,992	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	12,835	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	0	88,003	0	179,431	8.00
9.00	00900	HOUSEKEEPING	677	0	393,301	0	632,898	9.00
10.00	01000	DIETARY	3,703	5,811	207,002	0	554,862	10.00
11.00	01100	CAFETERIA	0	0	123,543	0	221,629	11.00
13.00	01300	NURSING ADMINISTRATION	1,492	0	129,385	0	200,862	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	901	0	55,050	0	162,527	14.00
15.00	01500	PHARMACY	0	0	199,151	0	340,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	0	298,954	0	625,667	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,069	830	1,051,565	0	1,503,685	30.00
31.00	03100	INTENSIVE CARE UNIT	787	0	34,397	0	58,609	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	6,426	1,239,020	0	1,667,845	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,813	141,453	602,692	0	1,162,249	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	13,020	428,596	0	1,479,206	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	134,294	55.00
60.00	06000	LABORATORY	4,944	53,055	606,493	0	1,749,050	60.00
65.00	06500	RESPIRATORY THERAPY	904	4,407	150,271	0	262,033	65.00
66.00	06600	PHYSICAL THERAPY	2,087	0	465,651	0	678,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	0	69,620	0	99,087	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	18,463	0	25,390	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	458,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	218,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,246,156	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	786,240	0	1,151,813	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	109,288	0	206,888	88.01
90.00	09000	CLINIC	6,871	1,481	0	0	662,654	90.00
90.01	09002	WOUND CARE	219	0	24,368	0	226,497	90.01
90.02	09003	PAIN MANAGEMENT	219	0	0	0	2,222	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	531	0	79,265	0	172,696	90.04
90.05	09005	DR BLASER	1,029	0	0	0	48,306	90.05
90.06	09006	DR. RONHOLM	219	0	36,196	0	56,014	90.06
90.07	09007	DR. BARKOVIAK	219	0	70,376	0	106,411	90.07
90.08	04950	NP LANGSTON	333	0	77,466	0	28,445	90.08
91.00	09100	EMERGENCY	2,819	1,374	1,154,678	0	2,279,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,195	57,413	0	133,909	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,804	520,587	9,929,306	-4,545,932	20,198,666	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	0	0	0	5,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,916	14,974	999,137	0	1,578,026	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,225,482	360,957	3,402,382		4,545,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.334374	0.673979	0.311333		0.208701	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,021		261,673	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000551		0.012013	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			7.00	7.01	7.02	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	80,863					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	73,992				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	6,871			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	2,252	0	394,524		8.00
9.00	00900	HOUSEKEEPING	677	677	0	28,567	77,934	9.00
10.00	01000	DIETARY	3,703	3,703	0	4,284	3,703	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,492	1,492	0	0	1,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	901	901	0	0	901	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	2,244	0	0	2,244	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,069	7,069	0	59,008	7,069	30.00
31.00	03100	INTENSIVE CARE UNIT	787	787	0	20	787	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	26,404	0	192,741	26,404	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,813	4,813	0	21,145	4,813	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	3,474	0	3,910	3,474	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	4,944	4,944	0	0	4,944	60.00
65.00	06500	RESPIRATORY THERAPY	904	904	0	82	904	65.00
66.00	06600	PHYSICAL THERAPY	2,087	2,087	0	17,140	2,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	170	0	0	170	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	6,871	0	6,871	0	6,871	90.00
90.01	09002	WOUND CARE	219	219	0	0	219	90.01
90.02	09003	PAIN MANAGEMENT	219	219	0	0	219	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	531	531	0	0	531	90.04
90.05	09005	DR BLASER	1,029	1,029	0	0	1,029	90.05
90.06	09006	DR. RONHOLM	219	219	0	0	219	90.06
90.07	09007	DR. BARKOVIAK	219	219	0	0	219	90.07
90.08	04950	NP LANGSTON	333	333	0	0	333	90.08
91.00	09100	EMERGENCY	2,819	2,819	0	32,486	2,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,380	67,509	6,871	359,383	71,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	567	0	0	567	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,916	5,916	0	210	5,916	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	132	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	34,799	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,014,578	736,089	15,514	267,537	799,585	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.546876	9.948224	2.257896	0.678126	10.259771	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	409,641	7,316	154	34,856	20,160	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.065864	0.098876	0.022413	0.088350	0.258680	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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	67,655					10.00
11.00	01100	CAFETERIA	0	11,865				11.00
13.00	01300	NURSING ADMINISTRATION	0	158	4,429			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	192	0	677,498		14.00
15.00	01500	PHARMACY	0	232	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	592	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,390	1,681	1,681	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	102	58	58	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	53,476	3,284	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	845	845	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	784	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	1,227	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	281	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	588	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	79	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	458,516	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	218,982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	3,687	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	1,731	1,731	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	114	114	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,655	11,865	4,429	677,498	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
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)	794,858	267,883	295,220	230,294	417,291	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.748696	22.577581	66.656130	0.339918	4,172.910000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,722	2,730	24,539	15,322	4,258	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.971429	0.230088	5.540528	0.022616	42.580000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
			10.00	11.00	13.00	14.00	15.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY				7.02
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,709,678			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,060,320	0		30.00
31.00	03100	INTENSIVE CARE UNIT	108,300	0		31.00
44.00	04400	SKILLED NURSING FACILITY	3,059,518	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,733,999	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,996,028	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	620,082	0		55.00
60.00	06000	LABORATORY	14,996,142	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,037,840	0		65.00
66.00	06600	PHYSICAL THERAPY	2,100,038	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	325,514	0		67.00
68.00	06800	SPEECH PATHOLOGY	47,235	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,273,776	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,002,367	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,714,477	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1,070,748	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	178,880	0		88.01
90.00	09000	CLINIC	2,096,980	0		90.00
90.01	09002	WOUND CARE	832,837	0		90.01
90.02	09003	PAIN MANAGEMENT	43,277	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	101,393	0		90.04
90.05	09005	DR BLASER	200,866	0		90.05
90.06	09006	DR. RONHOLM	64,597	0		90.06
90.07	09007	DR. BARKOVIAK	70,945	0		90.07
90.08	04950	NP LANGSTON	105,964	0		90.08
91.00	09100	EMERGENCY	7,666,539	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,201,016	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,709,678	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	0		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
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)	843,112	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.012271	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,933	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000596	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/28/2019 2:36 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 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	2,410,960		2,410,960	0	2,410,960	30.00
31.00	03100	INTENSIVE CARE UNIT	104,334		104,334	0	104,334	31.00
44.00	04400	SKILLED NURSING FACILITY	3,751,447		3,751,447	0	3,751,447	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,685,751		1,685,751	0	1,685,751	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,093,805		2,093,805	0	2,093,805	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,930		169,930	0	169,930	55.00
60.00	06000	LABORATORY	2,487,714		2,487,714	0	2,487,714	60.00
65.00	06500	RESPIRATORY THERAPY	377,736	0	377,736	0	377,736	65.00
66.00	06600	PHYSICAL THERAPY	939,219	0	939,219	0	939,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,113	0	131,113	0	131,113	67.00
68.00	06800	SPEECH PATHOLOGY	31,698	0	31,698	0	31,698	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	737,971		737,971	0	737,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	351,420		351,420	0	351,420	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,185		2,018,185	0	2,018,185	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,405,337		1,405,337	0	1,405,337	88.00
88.01	08801	RURAL HEALTH CLINIC II	252,261		252,261	0	252,261	88.01
90.00	09000	CLINIC	1,042,219		1,042,219	0	1,042,219	90.00
90.01	09002	WOUND CARE	291,161		291,161	0	291,161	90.01
90.02	09003	PAIN MANAGEMENT	10,391		10,391	0	10,391	90.02
90.03	09001	NEUROLOGY	0		0	0	0	90.03
90.04	09004	DR SKOW	227,375		227,375	0	227,375	90.04
90.05	09005	DR BLASER	94,558		94,558	0	94,558	90.05
90.06	09006	DR. RONHOLM	75,671		75,671	0	75,671	90.06
90.07	09007	DR. BARKOVIAK	136,664		136,664	0	136,664	90.07
90.08	04950	NP LANGSTON	46,589		46,589	0	46,589	90.08
91.00	09100	EMERGENCY	3,117,701		3,117,701	0	3,117,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	302,037		302,037		302,037	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	186,767		186,767	0	186,767	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,480,014	0	24,480,014	0	24,480,014	200.00
201.00		Less Observation Beds	302,037		302,037		302,037	201.00
202.00		Total (see instructions)	24,177,977	0	24,177,977	0	24,177,977	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,946,866		2,946,866			30.00
31.00	03100	INTENSIVE CARE UNIT	108,300		108,300			31.00
44.00	04400	SKILLED NURSING FACILITY	3,059,518		3,059,518			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	157,097	2,576,902	2,733,999	0.616588	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,509	13,339,519	13,996,028	0.149600	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	68,054	552,028	620,082	0.274044	0.000000	55.00
60.00	06000	LABORATORY	1,539,392	13,456,750	14,996,142	0.165890	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	629,223	1,408,617	2,037,840	0.185361	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	634,334	1,465,704	2,100,038	0.447239	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,731	132,783	325,514	0.402788	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	31,215	16,020	47,235	0.671070	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,295,299	978,477	2,273,776	0.324557	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	837,827	164,540	1,002,367	0.350590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,306,660	5,407,817	7,714,477	0.261610	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	54,604	1,016,144	1,070,748			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	178,880	178,880			88.01
90.00	09000	CLINIC	0	2,096,980	2,096,980	0.497010	0.000000	90.00
90.01	09002	WOUND CARE	12,931	819,906	832,837	0.349601	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	43,277	43,277	0.240104	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	0.000000	90.03
90.04	09004	DR SKOW	54	101,339	101,393	2.242512	0.000000	90.04
90.05	09005	DR BLASER	0	200,866	200,866	0.470752	0.000000	90.05
90.06	09006	DR. RONHOLM	0	64,597	64,597	1.171432	0.000000	90.06
90.07	09007	DR. BARKOVIAK	0	70,945	70,945	1.926337	0.000000	90.07
90.08	04950	NP LANGSTON	0	105,964	105,964	0.439668	0.000000	90.08
91.00	09100	EMERGENCY	5,576	7,660,963	7,666,539	0.406663	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,497	1,102,957	1,113,454	0.271261	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,201,016	1,201,016	0.155508	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,546,687	54,162,991	68,709,678			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,546,687	54,162,991	68,709,678			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.616588		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044		55.00
60.00	06000	LABORATORY	0.165890		60.00
65.00	06500	RESPIRATORY THERAPY	0.185361		65.00
66.00	06600	PHYSICAL THERAPY	0.447239		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788		67.00
68.00	06800	SPEECH PATHOLOGY	0.671070		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.497010		90.00
90.01	09002	WOUND CARE	0.349601		90.01
90.02	09003	PAIN MANAGEMENT	0.240104		90.02
90.03	09001	NEUROLOGY	0.000000		90.03
90.04	09004	DR SKOW	2.242512		90.04
90.05	09005	DR BLASER	0.470752		90.05
90.06	09006	DR. RONHOLM	1.171432		90.06
90.07	09007	DR. BARKOVIAK	1.926337		90.07
90.08	04950	NP LANGSTON	0.439668		90.08
91.00	09100	EMERGENCY	0.406663		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.155508		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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 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	2,410,960		2,410,960	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	104,334		104,334	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	3,751,447		3,751,447	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,685,751		1,685,751	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,093,805		2,093,805	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,930		169,930	0	0	55.00
60.00	06000	LABORATORY	2,487,714		2,487,714	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	377,736	0	377,736	0	0	65.00
66.00	06600	PHYSICAL THERAPY	939,219	0	939,219	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,113	0	131,113	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,698	0	31,698	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	737,971		737,971	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	351,420		351,420	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,018,185		2,018,185	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,405,337		1,405,337	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	252,261		252,261	0	0	88.01
90.00	09000	CLINIC	1,042,219		1,042,219	0	0	90.00
90.01	09002	WOUND CARE	291,161		291,161	0	0	90.01
90.02	09003	PAIN MANAGEMENT	10,391		10,391	0	0	90.02
90.03	09001	NEUROLOGY	0		0	0	0	90.03
90.04	09004	DR SKOW	227,375		227,375	0	0	90.04
90.05	09005	DR BLASER	94,558		94,558	0	0	90.05
90.06	09006	DR. RONHOLM	75,671		75,671	0	0	90.06
90.07	09007	DR. BARKOVIAK	136,664		136,664	0	0	90.07
90.08	04950	NP LANGSTON	46,589		46,589	0	0	90.08
91.00	09100	EMERGENCY	3,117,701		3,117,701	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	302,037		302,037		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	186,767		186,767	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,480,014	0	24,480,014	0	0	200.00
201.00		Less Observation Beds	302,037		302,037		0	201.00
202.00		Total (see instructions)	24,177,977	0	24,177,977	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,946,866		2,946,866			30.00
31.00	03100	INTENSIVE CARE UNIT	108,300		108,300			31.00
44.00	04400	SKILLED NURSING FACILITY	3,059,518		3,059,518			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	157,097	1,992,495	2,149,592	0.784219	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,509	13,339,519	13,996,028	0.149600	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	68,054	552,028	620,082	0.274044	0.000000	55.00
60.00	06000	LABORATORY	1,539,392	13,456,750	14,996,142	0.165890	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	629,223	1,408,617	2,037,840	0.185361	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	634,334	1,465,704	2,100,038	0.447239	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,731	132,783	325,514	0.402788	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	31,215	16,020	47,235	0.671070	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,295,299	978,477	2,273,776	0.324557	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	837,827	164,540	1,002,367	0.350590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,306,660	5,407,817	7,714,477	0.261610	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	54,604	1,016,144	1,070,748	1.312482	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	178,880	178,880	1.410225	0.000000	88.01
90.00	09000	CLINIC	0	2,096,980	2,096,980	0.497010	0.000000	90.00
90.01	09002	WOUND CARE	12,931	819,906	832,837	0.349601	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	43,277	43,277	0.240104	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	0.000000	90.03
90.04	09004	DR SKOW	54	101,339	101,393	2.242512	0.000000	90.04
90.05	09005	DR BLASER	0	200,866	200,866	0.470752	0.000000	90.05
90.06	09006	DR. RONHOLM	0	64,597	64,597	1.171432	0.000000	90.06
90.07	09007	DR. BARKOVIAK	0	70,945	70,945	1.926337	0.000000	90.07
90.08	04950	NP LANGSTON	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	5,576	7,660,963	7,666,539	0.406663	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,497	1,102,957	1,113,454	0.271261	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,201,016	1,201,016	0.155508	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,546,687	53,472,620	68,019,307			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,546,687	53,472,620	68,019,307			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/28/2019 2:36 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
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	WOUND CARE	0.000000		90.01
90.02	09003	PAIN MANAGEMENT	0.000000		90.02
90.03	09001	NEUROLOGY	0.000000		90.03
90.04	09004	DR SKOW	0.000000		90.04
90.05	09005	DR BLASER	0.000000		90.05
90.06	09006	DR. RONHOLM	0.000000		90.06
90.07	09007	DR. BARKOVIAK	0.000000		90.07
90.08	04950	NP LANGSTON	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/28/2019 2:36 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	189,032	2,733,999	0.069141	109,268	7,555	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,917	13,996,028	0.006210	372,004	2,310	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,983	620,082	0.003198	37,105	119	55.00
60.00	06000	LABORATORY	139,268	14,996,142	0.009287	772,740	7,176	60.00
65.00	06500	RESPIRATORY THERAPY	20,829	2,037,840	0.010221	284,313	2,906	65.00
66.00	06600	PHYSICAL THERAPY	42,109	2,100,038	0.020052	95,724	1,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,949	325,514	0.012132	15,853	192	67.00
68.00	06800	SPEECH PATHOLOGY	347	47,235	0.007346	6,162	45	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,233	2,273,776	0.007579	693,078	5,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,180	1,002,367	0.008161	591,333	4,826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,826	7,714,477	0.003088	851,389	2,629	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,908	1,070,748	0.013923	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,652	178,880	0.014826	0	0	88.01
90.00	09000	CLINIC	114,665	2,096,980	0.054681	0	0	90.00
90.01	09002	WOUND CARE	6,462	832,837	0.007759	919	7	90.01
90.02	09003	PAIN MANAGEMENT	3,285	43,277	0.075906	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0.000000	0	0	90.03
90.04	09004	DR SKOW	10,016	101,393	0.098784	0	0	90.04
90.05	09005	DR BLASER	15,886	200,866	0.079088	0	0	90.05
90.06	09006	DR. RONHOLM	3,963	64,597	0.061350	0	0	90.06
90.07	09007	DR. BARKOVIAK	4,591	70,945	0.064712	0	0	90.07
90.08	04950	NP LANGSTON	5,362	105,964	0.050602	0	0	90.08
91.00	09100	EMERGENCY	87,976	7,666,539	0.011475	1,126	13	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,911	1,113,454	0.016984	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	822,350	61,393,978		3,831,014	34,950	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,733,999	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,996,028	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	620,082	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	14,996,142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,037,840	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,100,038	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	47,235	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,273,776	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,002,367	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,714,477	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,070,748	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	178,880	0.000000	88.01
90.00	09000	CLINIC	0	0	0	2,096,980	0.000000	90.00
90.01	09002	WOUND CARE	0	0	0	832,837	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	43,277	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0.000000	90.03
90.04	09004	DR SKOW	0	0	0	101,393	0.000000	90.04
90.05	09005	DR BLASER	0	0	0	200,866	0.000000	90.05
90.06	09006	DR. RONHOLM	0	0	0	64,597	0.000000	90.06
90.07	09007	DR. BARKOVIAK	0	0	0	70,945	0.000000	90.07
90.08	04950	NP LANGSTON	0	0	0	105,964	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	7,666,539	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,113,454	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	61,393,978		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 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	109,268	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	372,004	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	37,105	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	772,740	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	284,313	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	95,724	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	15,853	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,162	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	693,078	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	591,333	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	851,389	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.000000	919	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	0.000000	0	0	0	0	90.04
90.05	09005	DR BLASER	0.000000	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0.000000	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	0.000000	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	1,126	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,831,014	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 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	0.616588	0	1,148,707	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	0	5,636,988	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	0	288,265	0	0	55.00
60.00	06000	LABORATORY	0.165890	0	6,181,261	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	0	675,559	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	0	565,095	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	0	67,236	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	0	1,855	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	0	327,197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	0	107,401	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	0	2,864,276	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.497010	0	1,902,606	0	0	90.00
90.01	09002	WOUND CARE	0.349601	0	487,306	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	9,083	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	21,868	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	24,204	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	10,084	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	15,039	0	0	90.07
90.08	04950	NP LANGSTON	0.439668	0	76,846	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	2,495,337	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	599,669	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.155508		0			95.00
200.00		Subtotal (see instructions)		0	23,505,882	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	23,505,882	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 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	708,279	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	843,293	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	78,997	0	55.00
60.00	06000	LABORATORY	1,025,409	0	60.00
65.00	06500	RESPIRATORY THERAPY	125,222	0	65.00
66.00	06600	PHYSICAL THERAPY	252,733	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,082	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,245	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,194	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,654	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	749,323	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	945,614	0	90.00
90.01	09002	WOUND CARE	170,363	0	90.01
90.02	09003	PAIN MANAGEMENT	2,181	0	90.02
90.03	09001	NEUROLOGY	0	0	90.03
90.04	09004	DR SKOW	49,039	0	90.04
90.05	09005	DR BLASER	11,394	0	90.05
90.06	09006	DR. RONHOLM	11,813	0	90.06
90.07	09007	DR. BARKOVIAK	28,970	0	90.07
90.08	04950	NP LANGSTON	33,787	0	90.08
91.00	09100	EMERGENCY	1,014,761	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	162,667	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,386,020	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,386,020	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 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	0.616588	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	0	0	0	0	55.00
60.00	06000	LABORATORY	0.165890	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.497010	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.349601	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	0	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.439668	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.155508		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: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
90.06	09006	DR. RONHOLM	0	0		90.06
90.07	09007	DR. BARKOVIAK	0	0		90.07
90.08	04950	NP LANGSTON	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346
Component CCN: 14-5499

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

Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,733,999	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,996,028	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	620,082	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	14,996,142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,037,840	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,100,038	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	47,235	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,273,776	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,002,367	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,714,477	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,070,748	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	178,880	0.000000	88.01
90.00	09000	CLINIC	0	0	0	2,096,980	0.000000	90.00
90.01	09002	WOUND CARE	0	0	0	832,837	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	43,277	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0.000000	90.03
90.04	09004	DR SKOW	0	0	0	101,393	0.000000	90.04
90.05	09005	DR BLASER	0	0	0	200,866	0.000000	90.05
90.06	09006	DR. RONHOLM	0	0	0	64,597	0.000000	90.06
90.07	09007	DR. BARKOVIAK	0	0	0	70,945	0.000000	90.07
90.08	04950	NP LANGSTON	0	0	0	105,964	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	7,666,539	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,113,454	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	61,393,978		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	3,081	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	98,806	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	29,212	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,798	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	43,357	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	0.000000	0	0	0	0	90.04
90.05	09005	DR BLASER	0.000000	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0.000000	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	0.000000	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		176,254	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | 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	0.784219	0	114,831	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	0	1,234,317	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	0	55,532	0	0	55.00
60.00	06000	LABORATORY	0.165890	0	990,645	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	0	104,166	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	0	76,252	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	0	8,191	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	0	595	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	0	51,370	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	0	555	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	0	339,180	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.312482				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.410225				0	88.01
90.00	09000	CLINIC	0.497010	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.349601	0	17,554	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	60,605	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	1,211,824	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	27,566	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.155508	0	140,432			95.00
200.00		Subtotal (see instructions)		0	4,433,615	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	4,433,615	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | 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	90,053	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,654	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,218	0		55.00
60.00	06000	LABORATORY	164,338	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,308	0		65.00
66.00	06600	PHYSICAL THERAPY	34,103	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,299	0		67.00
68.00	06800	SPEECH PATHOLOGY	399	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,672	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	195	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,733	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	6,137	0		90.01
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	135,907	0		90.04
90.05	09005	DR BLASER	0	0		90.05
90.06	09006	DR. RONHOLM	0	0		90.06
90.07	09007	DR. BARKOVIAK	0	0		90.07
90.08	04950	NP LANGSTON	0	0		90.08
91.00	09100	EMERGENCY	492,804	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,478	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	21,838			95.00
200.00		Subtotal (see instructions)	1,281,136	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,281,136	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 2:36 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)	3,517	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,993	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,581	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,232	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	292	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,132	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)	1,232	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,410,960	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)	46,711	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	949,890	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,461,070	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,461,070	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)	733.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	829,869	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)	829,869	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 2:36 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	104,334	56	1,863.11	33	61,483	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)	1,023,185	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,914,537	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)	903,179	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	903,179	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)	412	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	733.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	302,037	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 2:36 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	150,953	2,410,960	0.062611	302,037	18,911	90.00
91.00	Nursing School cost	0	2,410,960	0.000000	302,037	0	91.00
92.00	Allied health cost	0	2,410,960	0.000000	302,037	0	92.00
93.00	All other Medical Education	0	2,410,960	0.000000	302,037	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,911	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,911	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)	17,911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	340	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,751,447	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,751,447	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,751,447	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 14-5499 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,751,447	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	209.45	71.00
72.00	Program routine service cost (line 9 x line 71)	71,213	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	71,213	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	71,213	83.00
84.00	Program inpatient ancillary services (see instructions)	68,394	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	139,607	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,517	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,993	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,581	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,232	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	292	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	115	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,410,960	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)	46,711	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	949,890	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,461,070	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,461,070	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)	733.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	84,307	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)	84,307	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	104,334	56	1,863.11	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	65,252	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	149,559	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	412	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	733.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	302,037	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	150,953	2,410,960	0.062611	302,037	18,911	90.00
91.00	Nursing School cost	0	2,410,960	0.000000	302,037	0	91.00
92.00	Allied health cost	0	2,410,960	0.000000	302,037	0	92.00
93.00	All other Medical Education	0	2,410,960	0.000000	302,037	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 2:36 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		1,328,065		30.00
31.00	03100	INTENSIVE CARE UNIT		62,700		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.616588	109,268	67,373	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	372,004	55,652	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	37,105	10,168	55.00
60.00	06000	LABORATORY	0.165890	772,740	128,190	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	284,313	52,701	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	95,724	42,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	15,853	6,385	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	6,162	4,135	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	693,078	224,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	591,333	207,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	851,389	222,732	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.497010	0	0	90.00
90.01	09002	WOUND CARE	0.349601	919	321	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	90.07
90.08	04950	NP LANGSTON	0.439668	0	0	90.08
91.00	09100	EMERGENCY	0.406663	1,126	458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,831,014	1,023,185	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)		3,831,014		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.616588	8,131	5,013	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	82,046	12,274	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	4,652	1,275	55.00
60.00	06000	LABORATORY	0.165890	340,577	56,498	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	177,984	32,991	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	274,450	122,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	100,312	40,404	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	13,835	9,284	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	286,984	93,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	668,990	175,014	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.497010	0	0	90.00
90.01	09002	WOUND CARE	0.349601	7,778	2,719	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR SKOW	2.242512	54	121	90.04
90.05	09005	DR BLASER	0.470752	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	90.07
90.08	04950	NP LANGSTON	0.439668	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,965,793	551,481	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,965,793		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.616588	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	0	0	55.00
60.00	06000	LABORATORY	0.165890	3,081	511	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	98,806	44,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	29,212	11,766	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	1,798	584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	43,357	11,343	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.497010	0	0	90.00
90.01	09002	WOUND CARE	0.349601	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	90.07
90.08	04950	NP LANGSTON	0.439668	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		176,254	68,394	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)		176,254		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/28/2019 2:36 pm

Title XIX | 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		87,118		30.00
31.00	03100	INTENSIVE CARE UNIT		3,800		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.784219	6,881	5,396	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149600	18,466	2,763	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.274044	4,335	1,188	55.00
60.00	06000	LABORATORY	0.165890	60,521	10,040	60.00
65.00	06500	RESPIRATORY THERAPY	0.185361	18,141	3,363	65.00
66.00	06600	PHYSICAL THERAPY	0.447239	2,314	1,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402788	904	364	67.00
68.00	06800	SPEECH PATHOLOGY	0.671070	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324557	44,185	14,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.350590	32,550	11,412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261610	58,676	15,350	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.312482	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.410225	0	0	88.01
90.00	09000	CLINIC	0.497010	0	0	90.00
90.01	09002	WOUND CARE	0.349601	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.240104	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR SKOW	2.242512	0	0	90.04
90.05	09005	DR BLASER	0.470752	0	0	90.05
90.06	09006	DR. RONHOLM	1.171432	0	0	90.06
90.07	09007	DR. BARKOVIAK	1.926337	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.406663	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.271261	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		246,973	65,252	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)		246,973		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,386,020	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)	6,386,020	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)	6,449,880	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	67,984	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,553,665	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,828,231	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,828,231	30.00
31.00	Primary payer payments	324	31.00
32.00	Subtotal (line 30 minus line 31)	2,827,907	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)	899,562	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	584,715	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	715,619	36.00
37.00	Subtotal (see instructions)	3,412,622	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,412,622	40.00
40.01	Sequestration adjustment (see instructions)	68,252	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,129,897	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	214,473	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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,761,040		3,129,897	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	07/25/2018	125,300		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		125,300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,886,340		3,129,897	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		214,473	6.01
6.02	SETTLEMENT TO PROGRAM		226,079		0	6.02
7.00	Total Medicare program liability (see instructions)		1,660,261		3,344,370	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: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,292,258		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,292,258		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		121,629		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,413,887		0	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: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2019 2:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		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		109,262		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		109,262		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		109,262		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: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 2:36 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: 14-1346 Component CCN: 14-Z346	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/28/2019 2:36 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)	912,211	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)	556,996	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	1,232	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,469,207	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,469,207	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,469,207	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	26,465	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,442,742	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,442,742	0	19.00
19.01	Sequestration adjustment (see instructions)	28,855	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,292,258	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)	121,629	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: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,914,537	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,914,537	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,933,682	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,933,682	19.00
20.00	Deductibles (exclude professional component)	310,760	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,622,922	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,622,922	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	109,572	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	71,222	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	94,721	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,694,144	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,694,144	30.00
30.01	Sequestration adjustment (see instructions)	33,883	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,886,340	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)	-226,079	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	140,082	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	140,082	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	28,590	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	111,492	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	111,492	15.00
15.01	Sequestration adjustment (see instructions)	2,230	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	109,262	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 2:36 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	149,559		1.00
2.00	Medical and other services		1,281,136	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	151,055	1,293,947	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	151,055	1,293,947	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	246,973	4,433,615	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	246,973	4,433,615	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	246,973	4,433,615	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	95,918	3,139,668	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	151,055	1,293,947	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	151,055	1,293,947	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	151,055	1,293,947	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	151,055	1,293,947	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	151,055	1,293,947	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	151,055	1,293,947	40.00
41.00	Interim payments	149,398	1,352,900	41.00
42.00	Balance due provider/program (line 40 minus line 41)	1,657	-58,953	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 2:36 pm
	Title XIX	Skilled Nursing Facility	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/28/2019 2:36 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	-229,065	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	14,744,602	0	0	0	4.00
5.00	Other receivable	525,141	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,415,146	0	0	0	6.00
7.00	Inventory	342,929	0	0	0	7.00
8.00	Prepaid expenses	241,684	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,226,812	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,445,698	0	0	0	23.00
24.00	Accumulated depreciation	-5,191,546	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,898,111	0	0	0	27.00
28.00	Accumulated depreciation	-1,804,817	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)	1,347,446	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	4,336	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,336	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,578,594	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,740,258	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,126,221	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	704,671	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,571,150	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,101,995	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)	1,101,995	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,673,145	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,905,449				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)	1,905,449	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,578,594	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/28/2019 2:36 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		1,380,385		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		525,064				2.00
3.00	Total (sum of line 1 and line 2)		1,905,449		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)		1,905,449		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)		1,905,449		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: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2019 2:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,166,862		3,166,862	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,059,518		3,059,518	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)	6,226,380		6,226,380	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	108,300		108,300	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)	108,300		108,300	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,334,680		6,334,680	17.00
18.00	Ancillary services	8,385,364	41,153,443	49,538,807	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	54,604	1,016,144	1,070,748	20.00
20.01	RURAL HEALTH CLINIC II	0	178,880	178,880	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EMERGENCY	7,296	10,316,180	10,323,476	27.00
27.01	OBSERVATION	497	1,112,957	1,113,454	27.01
27.02	CLINIC	0	2,096,980	2,096,980	27.02
27.03	WOUND CARE	6,217	961,798	968,015	27.03
27.04	PAIN MANAGEMENT	0	255,332	255,332	27.04
27.05	DR SKOW	159,138	376,568	535,706	27.05
27.06	DR BLASER	66,567	2,286,429	2,352,996	27.06
27.07	DR RONHOLM	0	97,434	97,434	27.07
27.08	DR BARKOVIAK	0	121,319	121,319	27.08
27.09	AMBULANCE SERVICES	0	1,201,016	1,201,016	27.09
27.10	PHYSICIAN REVENUE	142,757	1,765,849	1,908,606	27.10
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,157,120	62,940,329	78,097,449	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,508,107		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		30,508,107		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/28/2019 2:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,097,449	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,739,751	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,357,698	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,508,107	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,150,409	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	86,558	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	4	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	974	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,587,937	24.00
25.00	Total other income (sum of lines 6-24)	1,675,473	25.00
26.00	Total (line 5 plus line 25)	525,064	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	525,064	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/28/2019 2:36 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	0	0	0	300,015	300,015	1.00
2.00	Physician Assistant	0	0	0	137,281	137,281	2.00
3.00	Nurse Practitioner	0	0	0	130,194	130,194	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	90,483	90,483	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	657,973	657,973	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	657,973	657,973	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	284	284	0	284	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	284	284	0	284	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	32,121	32,121	0	32,121	29.00
30.00	Administrative Costs	786,240	87,444	873,684	-657,973	215,711	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	786,240	119,565	905,805	-657,973	247,832	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	786,240	119,849	906,089	0	906,089	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/28/2019 2:36 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	300,015		1.00
2.00	Physician Assistant	0	137,281		2.00
3.00	Nurse Practitioner	0	130,194		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	90,483		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	657,973		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	657,973		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	284		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	284		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	32,121		29.00
30.00	Administrative Costs	942	216,653		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	942	248,774		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	942	907,031		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	43,360	43,360	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	39,881	39,881	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	83,241	83,241	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	83,241	83,241	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	39,781	39,781	0	39,781	29.00
30.00	Administrative Costs	109,288	27,831	137,119	-83,241	53,878	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	109,288	67,612	176,900	-83,241	93,659	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	109,288	67,612	176,900	0	176,900	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 14-8528 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	43,360		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	39,881		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	83,241		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	83,241		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	39,781		29.00
30.00	Administrative Costs	-4,037	49,841		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,037	89,622		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,037	172,863		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.86	2,351	4,200	3,612		1.00
2.00	Physician Assistant	0.78	2,409	2,100	1,638		2.00
3.00	Nurse Practitioner	1.11	2,716	2,100	2,331		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.75	7,476		7,581	7,581	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.75	7,476			7,581	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)					657,973	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					284	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					658,257	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999569	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					248,774	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					498,306	15.00
16.00	Total overhead (sum of lines 14 and 15)					747,080	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					747,080	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					746,758	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,404,731	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/28/2019 2:36 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.36	1,254	2,100	756		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.36	1,254		756	1,254	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.36	1,254			1,254	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)					83,241	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)					83,241	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)					89,622	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					79,398	15.00
16.00	Total overhead (sum of lines 14 and 15)					169,020	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					169,020	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					169,020	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					252,261	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,404,731	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,404,731	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,581	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)		7,581	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		185.30	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	185.30	185.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,634	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	302,780	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	302,780	16.00
16.01	Total program charges (see instructions)(from contractor's records)		237,697	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,590	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,120	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.)		211,955	16.04
16.05	Total program cost (see instructions)	0	219,075	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,716	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,266	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		219,075	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		219,075	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		219,075	26.00
26.01	Sequestration adjustment (see instructions)		4,382	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		208,550	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)		6,143	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/28/2019 2:36 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		252,261	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		252,261	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,254	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)		1,254	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		201.17	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	201.17	201.17	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	381	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	76,646	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	76,646	16.00
16.01	Total program charges (see instructions)(from contractor's records)		56,067	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,880	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,506	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.)		44,482	16.04
16.05	Total program cost (see instructions)	0	57,988	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,537	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,717	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		57,988	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		57,988	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		57,988	26.00
26.01	Sequestration adjustment (see instructions)		1,160	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		52,722	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)		4,106	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/28/2019 2:36 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		208,550	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		208,550	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		6,143	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		214,693	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/28/2019 2:36 pm

		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		52,722	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		52,722	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		4,106	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		56,828	7.00

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