

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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/29/2019 3:29 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 1/29/2019 Time: 3:29 pm  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

**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 THOMAS H BOYD CRITICAL ACC HOSPITAL ( 14-1300 ) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 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.

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) DEBORAH CAMPBELL  
 Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER  
 Title

(Dated when report is electronically signed.)  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	12,663	-103,800	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	27,447	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		77,362		0	10.00
200.00 Total	0	40,110	-26,438	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part I Date/Time Prepared: 1/29/2019 3:29 pm			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 800 SCHOOL STREET		PO Box:						
2.00	City: CARROLLTON		State: IL		Zip Code: 62016		County: GREENE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
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		THOMAS H BOYD CRITICAL ACC HOSPITAL		141300	99914	1	07/12/1999	N 0 N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		THOMAS H BOYD CRITICAL ACC SWING BED		14Z300	99914		07/12/1999	N 0 N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		GREENE COUNTY RHC		143403	99914		06/22/1995	N 0 N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2017	08/31/2018	
21.00	Type of Control (see instructions)						2		
							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.					3	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part I Date/Time Prepared: 1/29/2019 3:29 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	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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (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		XVII		XIX			
		1.00		2.00		3.00			
		Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
		Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
		NAHE 413.85 Y/N		Worksheet A Line #		Pass-Through Qualification Criterion Code			
		1.00		2.00		3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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	
64.00	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. 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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-2  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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				1.00	
<b>Long Term Care Hospital PPS</b>					
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	
<b>TEFRA Providers</b>					
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		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	Y	Y	N
				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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/29/2019 3:29 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		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	127,800	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.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		122.00
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/29/2019 3:29 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.					N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y	Y	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus 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)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2017	12/31/2017	170.00	
						1.00	
						2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet S-2 Part II Date/Time Prepared: 1/29/2019 3:29 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/31/2018	Y	12/31/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part II Date/Time Prepared: 1/29/2019 3:29 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		21.00
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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
<b>Purchased Services</b>						
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.					33.00
<b>Provider-Based Physicians</b>						
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	
<b>Home Office Costs</b>						
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		
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-2  
Part II  
Date/Time Prepared:  
1/29/2019 3:29 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	8,367.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	8,367.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	8,367.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 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)	241	11	352			1.00
2.00 HMO and other (see instructions)	46	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	316	0	405			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	284			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	557	11	1,041			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)	557	11	1,041	0.00	113.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	4,057	0	15,002	0.00	15.44	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	128.44	27.00
28.00 Observation Bed Days		0	122			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	93	8	144	1.00
2.00 HMO and other (see instructions)				14	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	93	8		144	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC (CONSOLIDATED)	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

Health Financial Systems		THOMAS H BOYD CRITICAL ACC HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1300 Component CCN: 14-3403		Period: From 09/01/2017 To 08/31/2018	
		RHC I		Worksheet S-8 Date/Time Prepared: 1/29/2019 3:29 pm	
				Cost	
				1.00	
1.00	1.00	Clinic Address and Identification Street		800 SCHOOL STREET	
		City		State	
		1.00		2.00	
2.00	2.00	City, State, ZIP Code, County		CARROLLTON IL 62016	
				1.00	
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	
		Grant Award		Date	
		1.00		2.00	
4.00	4.00	Source of Federal Funds			
5.00	5.00	Community Health Center (Section 330(d), PHS Act)			
6.00	6.00	Migrant Health Center (Section 329(d), PHS Act)			
7.00	7.00	Health Services for the Homeless (Section 340(d), PHS Act)			
8.00	8.00	Appalachian Regional Commission			
9.00	9.00	Look-Alikes			
9.00	9.00	OTHER (SPECIFY)			
				1.00	
10.00	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	
		Sunday		Monday	
		from to		from to	
		1.00 2.00		3.00 4.00	
				Tuesday	
				from	
				5.00	
11.00	11.00	Facility hours of operations (1)			
		CLINIC		08:00 16:00 07:00 19:00 07:00	
				1.00	
				2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		Y 4	
13.00	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.			
		Provider name		CCN number	
		1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number		GREENE COUNTY RURAL HEALTHC CLINIC 143403	
14.01	14.01			THOMAS H BOYD RURAL HEALTH CLINIC 143475	
14.02	14.02			BOYD-FILLAGER CLINIC - GREENFIELD 143474	
14.03	14.03			RURAL HEALTH CENTER OF ROODHOUSE 143476	
		Y/N		V	
		1.00		2.00	
				XVIII	
				XIX	
				Total Visits	
				5.00	
15.00	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)			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1300  
Component CCN: 14-3403

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet S-8  
Date/Time Prepared:  
1/29/2019 3:29 pm

		RHC I			Cost		
		County					
		4.00					
2.00	City, State, ZIP Code, County	GREENE COUNTY			2.00		
		Tuesday		Wednesday		Thursday	
		to		to		to	
		6.00		7.00		8.00	
		9.00		10.00			
Facility hours of operations (1)							
11.00	CLINIC	19:00	07:00	19:00	07:00	19:00	11.00
		Friday		Saturday			
		from		from		to	
		11.00		12.00		13.00	
		14.00					
Facility hours of operations (1)							
11.00	CLINIC	07:00	19:00	08:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet S-10 Date/Time Prepared: 1/29/2019 3:29 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.582840	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		963,572	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		0	5.00	
6.00	Medicaid charges		2,794,567	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,628,785	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)		665,213	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)		665,213	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)	12,379	6,797	19,176	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,215	6,797	14,012	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)	7,215	6,797	14,012	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)			1,062,649	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			113,441	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			174,525	27.01
28.00	Non-Medicare bad debt expense (see instructions)			888,124	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			578,718	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			592,730	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,257,943	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		101,593	101,593	-61,035	40,558	1.00
1.01	00101		0	0	8,025	8,025	1.01
2.00	00200		0	0	123,315	123,315	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	1,480,296	1,480,296	59,369	1,539,665	4.00
5.00	00500	975,587	920,093	1,895,680	247,714	2,143,394	5.00
7.00	00700	93,893	153,375	247,268	25,678	272,946	7.00
8.00	00800	24,813	4,101	28,914	0	28,914	8.00
9.00	00900	63,493	38,125	101,618	3,932	105,550	9.00
10.00	01000	161,264	53,016	214,280	0	214,280	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	105,205	11,189	116,394	0	116,394	13.00
14.00	01400	28,877	58,115	86,992	0	86,992	14.00
15.00	01500	0	236,939	236,939	0	236,939	15.00
16.00	01600	87,426	6,492	93,918	0	93,918	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	963,320	269,344	1,232,664	-57,225	1,175,439	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	390,419	145,769	536,188	-20,724	515,464	54.00
60.00	06000	403,719	375,509	779,228	1,126	780,354	60.00
63.00	06300	0	8,367	8,367	963	9,330	63.00
64.00	06400	997	0	997	0	997	64.00
66.00	06600	298,317	73,031	371,348	0	371,348	66.00
69.00	06900	0	13,080	13,080	20,061	33,141	69.00
71.00	07100	0	0	0	93,464	93,464	71.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,529,693	399,664	1,929,357	-319,700	1,609,657	88.00
90.00	09000	168,294	45,311	213,605	0	213,605	90.00
91.00	09100	1,183,076	489,213	1,672,289	-67,851	1,604,438	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	560,257	160,658	720,915	-25,754	695,161	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		39,014	39,014	-39,014	0	113.00
118.00		7,038,650	5,082,294	12,120,944	-7,656	12,113,288	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	57,296	1,423	58,719	7,656	66,375	194.00
200.00		7,095,946	5,083,717	12,179,663	0	12,179,663	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
	00101			1.01
2.00	00200			2.00
3.00	00300			3.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400			54.00
60.00	06000			60.00
63.00	06300			63.00
64.00	06400			64.00
66.00	06600			66.00
69.00	06900			69.00
71.00	07100			71.00
73.00	07300			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800			88.00
90.00	09000			90.00
91.00	09100			91.00
92.00	09200			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500			95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300			113.00
118.00				118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
194.00	07951			194.00
200.00				200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - DEPRECIATION EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	5,730	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	69,840	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	7,472	3.00
	O		0	83,042	
<b>B - INTEREST EXPENSE</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	13,250	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	25,764	2.00
	O		0	39,014	
<b>C - EKG SALARIES</b>					
1.00	ELECTROCARDIOLOGY	69.00	18,635	1,426	1.00
2.00		0.00	0	0	2.00
	O		18,635	1,426	
<b>E - RHC ADMIN COSTS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59,369	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	21,313	2.00
3.00	OPERATION OF PLANT	7.00	0	17,591	3.00
	O		0	98,273	
<b>F - RHC BUSINESS OFFICE AND HOUSEKEEPING</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	226,889	12,325	1.00
2.00	HOUSEKEEPING	9.00	3,681	251	2.00
	O		230,570	12,576	
<b>G - RHC LAB TIME</b>					
1.00	LABORATORY	60.00	1,958	131	1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	897	66	2.00
	O		2,855	197	
<b>H - ER ADMIN TIME</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	4,595	2,417	1.00
	O		4,595	2,417	
<b>I - LEASE EXPENSE</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	14,200	1.00
	O		0	14,200	
<b>L - PROPERTY TAXES</b>					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	1,570	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	5,273	2.00
3.00	WELLNESS	194.00	0	7,656	3.00
	O		0	14,499	
<b>M - CONTINUING EDUCATION COSTS IN ER</b>					
1.00	RURAL HEALTH CLINIC	88.00	0	11,063	1.00
	O		0	11,063	
<b>N - PROPERTY INSURANCE</b>					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	48,757	1.00
2.00		0.00	0	0	2.00
	O		0	48,757	
<b>O - AMBULANCE OVERHEAD</b>					
1.00	OPERATION OF PLANT	7.00	0	8,087	1.00
	O		0	8,087	
<b>P - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	93,464	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	93,464	
500.00	Grand Total: Increases		256,655	427,015	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - DEPRECIATION EXPENSE</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	83,042	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	O		0	83,042			
<b>B - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	39,014	11		1.00
2.00		0.00	0	0	0		2.00
	O		0	39,014			
<b>C - EKG SALARIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	8,127	622	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	10,508	804	0		2.00
	O		18,635	1,426			
<b>E - RHC ADMIN COSTS</b>							
1.00	RURAL HEALTH CLINIC	88.00	0	98,273	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		0	98,273			
<b>F - RHC BUSINESS OFFICE AND HOUSEKEEPING</b>							
1.00	RURAL HEALTH CLINIC	88.00	230,570	12,576	0		1.00
2.00		0.00	0	0	0		2.00
	O		230,570	12,576			
<b>G - RHC LAB TIME</b>							
1.00	LABORATORY	60.00	897	66	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	1,958	131	0		2.00
	O		2,855	197			
<b>H - ER ADMIN TIME</b>							
1.00	EMERGENCY	91.00	4,595	2,417	0		1.00
	O		4,595	2,417			
<b>I - LEASE EXPENSE</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	14,200	10		1.00
	O		0	14,200			
<b>L - PROPERTY TAXES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,499	13		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		0	14,499			
<b>M - CONTINUING EDUCATION COSTS IN ER</b>							
1.00	EMERGENCY	91.00	0	11,063	0		1.00
	O		0	11,063			
<b>N - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,090	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	17,667	0		2.00
	O		0	48,757			
<b>O - AMBULANCE OVERHEAD</b>							
1.00	AMBULANCE SERVICES	95.00	0	8,087	0		1.00
	O		0	8,087			
<b>P - MEDICAL SUPPLIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	34,276	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,412	0		2.00
3.00	EMERGENCY	91.00	0	49,776	0		3.00
	O		0	93,464			
500.00	Grand Total: Decreases		256,655	427,015			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A-7  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	70,514	0	0	0	0	1.00
2.00	Land Improvements	36,143	13,680	0	13,680	0	2.00
3.00	Buildings and Fixtures	1,389,236	13,426	0	13,426	0	3.00
4.00	Building Improvements	1,188,414	0	0	0	0	4.00
5.00	Fixed Equipment	84,028	0	0	0	0	5.00
6.00	Movable Equipment	3,155,027	448,926	0	448,926	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,923,362	476,032	0	476,032	0	8.00
9.00	Reconciling Items	-13,426	-7,644	0	-7,644	-13,426	9.00
10.00	Total (line 8 minus line 9)	5,936,788	483,676	0	483,676	13,426	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	70,514	0				1.00
2.00	Land Improvements	49,823	0				2.00
3.00	Buildings and Fixtures	1,402,662	0				3.00
4.00	Building Improvements	1,188,414	0				4.00
5.00	Fixed Equipment	84,028	0				5.00
6.00	Movable Equipment	3,603,953	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	6,399,394	0				8.00
9.00	Reconciling Items	-7,644	0				9.00
10.00	Total (line 8 minus line 9)	6,407,038	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A-7  
Part II  
Date/Time Prepared:  
1/29/2019 3:29 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	101,593	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	101,593	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	101,593				1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	101,593				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A-7  
Part III  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,706,345	0	2,706,345	0.451367	22,007	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	89,096	0	89,096	0.014860	725	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,603,953	403,506	3,200,447	0.533773	26,025	2.00
3.00	Total (sum of lines 1-2)	6,399,394	403,506	5,995,888	1.000000	48,757	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	22,007	13,079	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	725	5,730	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	26,025	69,840	14,200	2.00
3.00	Total (sum of lines 1-2)	0	0	48,757	88,649	14,200	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 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	22,007	0	0	35,086	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	725	1,570	0	8,025	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	26,025	0	0	110,065	2.00
3.00	Total (sum of lines 1-2)	0	48,757	1,570	0	153,176	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A-8

Date/Time Prepared:  
1/29/2019 3:29 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)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)			0CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01		0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-13,250	NEW CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00 Investment income - other (chapter 2)	B	-20,483	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)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-6,173	ADMINISTRATIVE & GENERAL	5.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-368,409				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-33,163	DIETARY	10.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-5,268	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL 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			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.			0CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01		0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00			30.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00 INTEREST EXPENSE - MEDICARE	A	-5,281		ADMINISTRATIVE & GENERAL	5.00		0 33.00
33.01 HEALTHLINK ADMIN FEES	A	13,282		ADMINISTRATIVE & GENERAL	5.00		0 33.01
33.02 PHYSICIAN BENEFITS	A	-9,807		EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.02
33.03 MISC INC - ADMIN	B	-110		ADMINISTRATIVE & GENERAL	5.00		0 33.03
33.04 MISC INC - CPR	B	-300		AMBULANCE SERVICES	95.00		0 33.04
33.05 MISC INC - CHART REVIEW	B	-4,290		MEDICAL RECORDS & LIBRARY	16.00		0 33.05
33.06 HEALTH FAIR	B	-7,410		ADMINISTRATIVE & GENERAL	5.00		0 33.06
33.07 IHA LOBBYING DUES	A	-2,891		ADMINISTRATIVE & GENERAL	5.00		0 33.07
33.08 AMBULANCE SUBSIDY - OPERATIONS	B	-353,196		AMBULANCE SERVICES	95.00		0 33.08
33.09 MEDICAID ASSESSMENT TAX	A	-124,283		ADMINISTRATIVE & GENERAL	5.00		0 33.09
33.10 NON-ALLOWABLE EHR LEASE EXPENSE	A	-37,778		ADMINISTRATIVE & GENERAL	5.00		0 33.10
33.11 OTHER ADJUSTMENTS (SPECIFY (3))		0			0.00		0 33.11
33.12 ENT RETAIL SALES	A	-6,392		CLINIC	90.00		0 33.12
33.13 VENDOR DEBT FORGIVENESS	A	-381,990		ADMINISTRATIVE & GENERAL	5.00		0 33.13
33.14 GOODWILL AMORTIZATION	A	-5,472		NEW CAP REL COSTS-BLDG & FI XT	1.00		9 33.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,372,664					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet A-8-2

Date/Time Prepared:  
1/29/2019 3:29 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,080,363	215,533	864,830	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	6,783	0	6,783	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	23,129	23,129	0	0	0	3.00
4.00	60.00	LABORATORY	6,000	0	6,000	0	0	4.00
5.00	90.00	CLINIC	116,667	116,667	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	13,080	13,080	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,246,022	368,409	877,613			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	215,533	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	23,129	3.00
4.00	60.00	LABORATORY	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	116,667	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	13,080	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	368,409	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/29/2019 3:29 pm	
				Occupational Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					23	1.00
2.00	Line 1 multiplied by 15 hours per week					345	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					116	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	246.17	160.06	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.94	57.71	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.47	38.47	28.86			11.00
12.00	Number of travel hours (provider site)	0	143	137			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					18,940	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					9,237	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					28,177	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					28,177	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					28,177	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					4,463	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,463	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					626	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,089	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					11,002	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					7,906	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					18,908	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,089	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/29/2019 3:29 pm	
		Occupational Therapy		Cost			
				1.00			
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.94	57.71	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					28,177	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					5,089	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					33,266	63.00
64.00	Total cost of outside supplier services (from your records)					23,894	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					4,463	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					626	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					5,089	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					626	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					18,908	101.01
101.02	Line 34 = sum of lines 27 and 31					19,534	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					18,908	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					18,908	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/29/2019 3:29 pm	
		Speech Pathology		Cost			
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					12	1.00
2.00	Line 1 multiplied by 15 hours per week					180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					25	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	33.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.97	36.97	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					2,459	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,459	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,459	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.95	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					13,311	22.00
23.00	Total salary equivalency (see instructions)					13,311	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					924	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					924	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					135	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,059	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,059	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300				Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/29/2019 3:29 pm
		Speech Pathology				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.94	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					13,311	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					1,059	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					14,370	63.00
64.00	Total cost of outside supplier services (from your records)					1,995	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					924	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					135	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,059	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					135	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					135	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	35,086	35,086			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	8,025	0	8,025		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	110,065			110,065	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,529,858	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,570,277	4,098	980	29,679	5.00
7.00 00700	OPERATION OF PLANT	272,946	1,286	0	224	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	28,914	1,235	0	0	8.00
9.00 00900	HOUSEKEEPING	105,550	343	0	0	9.00
10.00 01000	DIETARY	181,117	3,643	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	116,394	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	86,992	692	0	0	14.00
15.00 01500	PHARMACY	236,939	475	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	84,360	886	0	371	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,152,310	10,976	0	33,697	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	515,464	1,788	0	20,940	54.00
60.00 06000	LABORATORY	780,354	947	0	3,879	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	9,330	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	997	0	0	0	64.00
66.00 06600	PHYSICAL THERAPY	371,348	2,110	0	19,243	66.00
69.00 06900	ELECTROCARDIOLOGY	20,061	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,464	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,609,657	2,037	0	0	88.00
90.00 09000	CLINIC	90,546	777	0	934	90.00
91.00 09100	EMERGENCY	1,388,905	3,266	0	1,098	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	341,665	527	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10,740,624	35,086	980	110,065	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07951	WELLNESS	66,375	0	7,045	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	10,806,999	35,086	8,025	110,065	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:  
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,876,195	1,876,195			5.00
7.00	00700	OPERATION OF PLANT	295,548	62,089	357,637		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,723	7,505	14,873	58,101	8.00
9.00	00900	HOUSEKEEPING	120,983	25,416	4,128	6,132	156,659
10.00	01000	DIETARY	220,987	46,425	43,869	926	7,202
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	140,028	29,417	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	94,171	19,784	8,335	0	0
15.00	01500	PHARMACY	237,414	49,876	5,720	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	105,257	22,112	10,666	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,406,366	295,451	132,162	25,764	105,954
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,537	130,993	21,525	4,472	8,867
60.00	06000	LABORATORY	876,111	184,054	11,405	0	8,259
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,532	2,002	0	0	0
64.00	06400	INTRAVENOUS THERAPY	1,221	257	0	0	0
66.00	06600	PHYSICAL THERAPY	459,716	96,578	25,403	2,980	0
69.00	06900	ELECTROCARDIOLOGY	24,247	5,094	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,464	19,635	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	1,903,096	399,808	24,527	165	11,268
90.00	09000	CLINIC	103,855	21,818	9,358	0	192
91.00	09100	EMERGENCY	1,625,207	341,425	39,321	10,698	13,252
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	468,050	98,328	6,345	6,844	1,665
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,720,708	1,858,067	357,637	57,981	156,659
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	WELLNESS	86,291	18,128	0	120	0
200.00		Cross Foot Adjustments	0				0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	10,806,999	1,876,195	357,637	58,101	156,659

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	319,409					10.00
11.00	01100	244,488	244,488				11.00
13.00	01300	0	4,902	174,347			13.00
14.00	01400	0	3,257	0	125,547		14.00
15.00	01500	0	0	0	0	293,010	15.00
16.00	01600	0	7,127	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	74,921	55,888	115,897	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	21,446	0	0	0	54.00
60.00	06000	0	26,832	0	0	0	60.00
63.00	06300	0	65	0	0	0	63.00
64.00	06400	0	65	0	0	0	64.00
66.00	06600	0	14,771	0	0	0	66.00
69.00	06900	0	1,064	0	0	0	69.00
71.00	07100	0	0	0	125,547	0	71.00
73.00	07300	0	0	0	0	293,010	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	18,157	0	0	0	88.00
90.00	09000	0	3,580	0	0	0	90.00
91.00	09100	0	41,732	58,450	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	42,280	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		319,409	241,166	174,347	125,547	293,010	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	0	3,322	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		319,409	244,488	174,347	125,547	293,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:  
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.				1.01
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
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	145,162			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	19,934	2,232,337	-96,192	2,136,145
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,129	833,969	0	833,969
60.00	06000	LABORATORY	36,163	1,142,824	0	1,142,824
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,599	0	11,599
64.00	06400	INTRAVENOUS THERAPY	0	1,543	649,420	650,963
66.00	06600	PHYSICAL THERAPY	6,325	605,773	0	605,773
69.00	06900	ELECTROCARDIOLOGY	0	30,405	0	30,405
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238,646	0	238,646
73.00	07300	DRUGS CHARGED TO PATIENTS	0	293,010	0	293,010
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	192	2,357,213	0	2,357,213
90.00	09000	CLINIC	0	138,803	0	138,803
91.00	09100	EMERGENCY	51,816	2,181,901	-553,228	1,628,673
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	7,603	631,115	0	631,115
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,162	10,699,138	0	10,699,138
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00	07951	WELLNESS	0	107,861	0	107,861
200.00		Cross Foot Adjustments		0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	145,162	10,806,999	0	10,806,999

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

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Part II  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	4,098	980	29,679	5.00
7.00 00700	OPERATION OF PLANT	0	1,286	0	224	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,235	0	0	8.00
9.00 00900	HOUSEKEEPING	0	343	0	0	9.00
10.00 01000	DIETARY	0	3,643	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	692	0	0	14.00
15.00 01500	PHARMACY	0	475	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	886	0	371	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	10,976	0	33,697	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,788	0	20,940	54.00
60.00 06000	LABORATORY	0	947	0	3,879	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00 06600	PHYSICAL THERAPY	0	2,110	0	19,243	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	2,037	0	0	88.00
90.00 09000	CLINIC	0	777	0	934	90.00
91.00 09100	EMERGENCY	0	3,266	0	1,098	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	527	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	35,086	980	110,065	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07951	WELLNESS	0	0	7,045	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	35,086	8,025	110,065	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	34,757			5.00
7.00	00700	OPERATION OF PLANT	0	1,150	2,660		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139	111	1,485	8.00
9.00	00900	HOUSEKEEPING	0	471	31	157	1,002
10.00	01000	DIETARY	0	860	326	24	46
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	545	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	367	62	0	0
15.00	01500	PHARMACY	0	924	43	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	410	79	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	5,474	983	659	677
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,427	160	114	57
60.00	06000	LABORATORY	0	3,410	85	0	53
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	37	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	5	0	0	0
66.00	06600	PHYSICAL THERAPY	0	1,789	189	76	0
69.00	06900	ELECTROCARDIOLOGY	0	94	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	364	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	7,404	182	4	72
90.00	09000	CLINIC	0	404	70	0	1
91.00	09100	EMERGENCY	0	6,325	292	273	85
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	1,822	47	175	11
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	34,421	2,660	1,482	1,002
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	WELLNESS	0	336	0	3	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	34,757	2,660	1,485	1,002

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	4,899					10.00
11.00	01100	3,750	3,750				11.00
13.00	01300	0	75	620			13.00
14.00	01400	0	50	0	1,171		14.00
15.00	01500	0	0	0	0	1,442	15.00
16.00	01600	0	109	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,149	858	412	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	329	0	0	0	54.00
60.00	06000	0	412	0	0	0	60.00
63.00	06300	0	1	0	0	0	63.00
64.00	06400	0	1	0	0	0	64.00
66.00	06600	0	227	0	0	0	66.00
69.00	06900	0	16	0	0	0	69.00
71.00	07100	0	0	0	1,171	0	71.00
73.00	07300	0	0	0	0	1,442	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	278	0	0	0	88.00
90.00	09000	0	55	0	0	0	90.00
91.00	09100	0	640	208	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	648	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		4,899	3,699	620	1,171	1,442	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	0	51	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,899	3,750	620	1,171	1,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Prepared: 1/29/2019 3:29 pm
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.				1.01	
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	
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	1,855			16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	255	55,140	0	55,140	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	296	26,111	0	26,111	54.00
60.00	06000	LABORATORY	462	9,248	0	9,248	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	38	0	38	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6	0	6	64.00
66.00	06600	PHYSICAL THERAPY	81	23,715	0	23,715	66.00
69.00	06900	ELECTROCARDIOLOGY	0	110	0	110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,535	0	1,535	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,442	0	1,442	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	2	9,979	0	9,979	88.00
90.00	09000	CLINIC	0	2,241	0	2,241	90.00
91.00	09100	EMERGENCY	662	12,849	0	12,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	97	3,327	0	3,327	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,855	145,741	0	145,741	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	WELLNESS	0	7,435	0	7,435	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,855	153,176	0	153,176	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)			
	1.00	1.01	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	37,153				1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074			1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			84,040		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	6,810,139	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,339	864	22,661	1,207,071	5.00
7.00 00700	OPERATION OF PLANT	1,362	0	171	93,893	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,308	0	0	24,813	8.00
9.00 00900	HOUSEKEEPING	363	0	0	67,174	9.00
10.00 01000	DIETARY	3,858	0	0	161,264	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	105,205	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	733	0	0	28,877	14.00
15.00 01500	PHARMACY	503	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	938	0	283	87,426	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	11,623	0	25,730	932,064	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,893	0	15,989	379,910	54.00
60.00 06000	LABORATORY	1,003	0	2,962	404,780	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	897	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	997	64.00
66.00 06600	PHYSICAL THERAPY	2,234	0	14,693	298,317	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	18,635	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	2,157	0	0	1,297,165	88.00
90.00 09000	CLINIC	823	0	713	51,627	90.00
91.00 09100	EMERGENCY	3,458	0	838	1,032,471	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	558	0	0	560,257	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	37,153	864	84,040	6,752,843	-1,876,195
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07951	WELLNESS	0	6,210	0	57,296	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	35,086	8,025	110,065	1,529,858	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.944365	1.134436	1.309674	0.224644	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000	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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet B-1

Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,930,804				5.00
7.00	00700	OPERATION OF PLANT	295,548	31,452			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,723	1,308	38,135		8.00
9.00	00900	HOUSEKEEPING	120,983	363	4,025	73,410	9.00
10.00	01000	DIETARY	220,987	3,858	608	3,375	16,810
11.00	01100	CAFETERIA	0	0	0	0	12,867
13.00	01300	NURSING ADMINISTRATION	140,028	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	94,171	733	0	0	0
15.00	01500	PHARMACY	237,414	503	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	105,257	938	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,406,366	11,623	16,910	49,650	3,943
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,537	1,893	2,935	4,155	0
60.00	06000	LABORATORY	876,111	1,003	0	3,870	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,532	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	1,221	0	0	0	0
66.00	06600	PHYSICAL THERAPY	459,716	2,234	1,956	0	0
69.00	06900	ELECTROCARDIOLOGY	24,247	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,464	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	1,903,096	2,157	108	5,280	0
90.00	09000	CLINIC	103,855	823	0	90	0
91.00	09100	EMERGENCY	1,625,207	3,458	7,022	6,210	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	468,050	558	4,492	780	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,844,513	31,452	38,056	73,410	16,810
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	WELLNESS	86,291	0	79	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,876,195	357,637	58,101	156,659	319,409
203.00		Unit cost multiplier (Wkst. B, Part I)	0.210081	11.370883	1.523561	2.134028	19.001130
204.00		Cost to be allocated (per Wkst. B, Part II)	34,757	2,660	1,485	1,002	4,899
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003892	0.084573	0.038941	0.013649	0.291434
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet B-1

Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	7,581					11.00
13.00	01300	152	2,607				13.00
14.00	01400	101	0	100			14.00
15.00	01500	0	0	0	100		15.00
16.00	01600	221	0	0	0	56,800	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,733	1,733	0	0	7,800	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	665	0	0	0	9,050	54.00
60.00	06000	832	0	0	0	14,150	60.00
63.00	06300	2	0	0	0	0	63.00
64.00	06400	2	0	0	0	0	64.00
66.00	06600	458	0	0	0	2,475	66.00
69.00	06900	33	0	0	0	0	69.00
71.00	07100	0	0	100	0	0	71.00
73.00	07300	0	0	0	100	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	563	0	0	0	75	88.00
90.00	09000	111	0	0	0	0	90.00
91.00	09100	1,294	874	0	0	20,275	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	1,311	0	0	0	2,975	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		7,478	2,607	100	100	56,800	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07951	103	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		244,488	174,347	125,547	293,010	145,162	202.00
203.00		32.250099	66.876486	1,255.470000	2,930.100000	2.555669	203.00
204.00		3,750	620	1,171	1,442	1,855	204.00
205.00		0.494658	0.237821	11.710000	14.420000	0.032658	205.00
206.00							206.00
207.00							207.00

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet B-2  
Date/Time Prepared:  
1/29/2019 3:29 pm

	Description	Worksheet		Amount	
		CODE	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00
7.00	IV THERAPY		1 30.00	-96,192	7.00
8.00	IV THERAPY		1 64.00	649,420	8.00
9.00	IV THERAPY		1 91.00	-553,228	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,136,145		2,136,145	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	833,969		833,969	0	0	54.00
60.00	06000 LABORATORY	1,142,824		1,142,824	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	11,599		11,599	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	650,963		650,963	0	0	64.00
66.00	06600 PHYSICAL THERAPY	605,773	0	605,773	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	30,405		30,405	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	238,646		238,646	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	293,010		293,010	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	2,357,213		2,357,213	0	0	88.00
90.00	09000 CLINIC	138,803		138,803	0	0	90.00
91.00	09100 EMERGENCY	1,628,673		1,628,673	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	290,359		290,359	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	631,115		631,115	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	10,989,497	0	10,989,497	0	0	200.00
201.00	Less Observation Beds	290,359		290,359			201.00
202.00	Total (see instructions)	10,699,138	0	10,699,138	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			Cost		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	720,020		720,020			30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	68,684	4,118,119	4,186,803	0.199190	0.000000	54.00
60.00	06000 LABORATORY	140,894	4,152,652	4,293,546	0.266173	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,832	47,996	50,828	0.228201	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	1,334	680,193	681,527	0.955154	0.000000	64.00
66.00	06600 PHYSICAL THERAPY	203,598	995,701	1,199,299	0.505106	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	2,334	429,380	431,714	0.070429	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226,394	206,658	433,052	0.551079	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	256,172	361,034	617,206	0.474736	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,492,014	2,492,014			88.00
90.00	09000 CLINIC	0	131,764	131,764	1.053421	0.000000	90.00
91.00	09100 EMERGENCY	1,896	1,246,332	1,248,228	1.304788	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	157,236	157,236	1.846645	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	1,713,676	1,713,676	0.368281	0.000000	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	1,624,158	16,732,755	18,356,913			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	1,624,158	16,732,755	18,356,913			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 1/29/2019 3:29 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital
				Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

		Title XIX		Hospital		
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	2,136,145		2,136,145	0	2,136,145 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400 RADIOLOGY-DIAGNOSTIC	833,969		833,969	0	833,969 54.00
60.00	06000 LABORATORY	1,142,824		1,142,824	0	1,142,824 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	11,599		11,599	0	11,599 63.00
64.00	06400 INTRAVENOUS THERAPY	650,963		650,963	0	650,963 64.00
66.00	06600 PHYSICAL THERAPY	605,773	0	605,773	0	605,773 66.00
69.00	06900 ELECTROCARDIOLOGY	30,405		30,405	0	30,405 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	238,646		238,646	0	238,646 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	293,010		293,010	0	293,010 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	2,357,213		2,357,213	0	2,357,213 88.00
90.00	09000 CLINIC	138,803		138,803	0	138,803 90.00
91.00	09100 EMERGENCY	1,628,673		1,628,673	0	1,628,673 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	290,359		290,359		290,359 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	631,115		631,115	0	631,115 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	10,989,497	0	10,989,497	0	10,989,497 200.00
201.00	Less Observation Beds	290,359		290,359		290,359 201.00
202.00	Total (see instructions)	10,699,138	0	10,699,138	0	10,699,138 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX		Hospital					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	720,020		720,020		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,684	4,118,119	4,186,803	0.199190	54.00
60.00	06000	LABORATORY	140,894	4,152,652	4,293,546	0.266173	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,832	47,996	50,828	0.228201	63.00
64.00	06400	INTRAVENOUS THERAPY	1,334	680,193	681,527	0.955154	64.00
66.00	06600	PHYSICAL THERAPY	203,598	995,701	1,199,299	0.505106	66.00
69.00	06900	ELECTROCARDIOLOGY	2,334	429,380	431,714	0.070429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	226,394	206,658	433,052	0.551079	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,172	361,034	617,206	0.474736	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,492,014	2,492,014	0.945907	88.00
90.00	09000	CLINIC	0	131,764	131,764	1.053421	90.00
91.00	09100	EMERGENCY	1,896	1,246,332	1,248,228	1.304788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	157,236	157,236	1.846645	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,713,676	1,713,676	0.368281	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,624,158	16,732,755	18,356,913		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,624,158	16,732,755	18,356,913		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Prepared: 1/29/2019 3:29 pm
		Title XIX	Hospital	

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
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
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet D Part II Date/Time Prepared: 1/29/2019 3:29 pm	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,111	4,186,803	0.006237	44,753	279	54.00
60.00	06000	LABORATORY	9,248	4,293,546	0.002154	65,531	141	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	38	50,828	0.000748	1,888	1	63.00
64.00	06400	INTRAVENOUS THERAPY	6	681,527	0.000009	0	0	64.00
66.00	06600	PHYSICAL THERAPY	23,715	1,199,299	0.019774	18,303	362	66.00
69.00	06900	ELECTROCARDIOLOGY	110	431,714	0.000255	1,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,535	433,052	0.003545	86,815	308	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,442	617,206	0.002336	91,575	214	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	9,979	2,492,014	0.004004	0	0	88.00
90.00	09000	CLINIC	2,241	131,764	0.017008	0	0	90.00
91.00	09100	EMERGENCY	12,849	1,248,228	0.010294	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,495	157,236	0.047667	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	94,769	15,923,217		309,930	1,305	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/29/2019 3:29 pm
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Cost Center Description		Title XVIII				Hospital		
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost	
		1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/29/2019 3:29 pm
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Cost Center Description		Title XVIII			Hospital	Cost		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,186,803	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,293,546	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	50,828	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	681,527	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,199,299	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	431,714	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	433,052	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	617,206	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,492,014	0.000000	88.00
90.00	09000	CLINIC	0	0	0	131,764	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,248,228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	157,236	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	15,923,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part IV Date/Time Prepared: 1/29/2019 3:29 pm
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	44,753	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	65,531	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	1,888	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.000000	18,303	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,065	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	86,815	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	91,575	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		309,930	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/29/2019 3:29 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges	Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199190	0	1,536,664	0	54.00
60.00	06000	LABORATORY	0.266173	0	1,856,655	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.228201	0	34,453	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.955154	0	331,565	0	64.00
66.00	06600	PHYSICAL THERAPY	0.505106	0	346,374	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.070429	0	215,586	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.551079	0	101,852	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474736	0	155,138	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
90.00	09000	CLINIC	1.053421	0	25,229	0	90.00
91.00	09100	EMERGENCY	1.304788	0	433,986	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.846645	0	97,524	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0.368281		0		95.00
200.00		Subtotal (see instructions)		0	5,135,026	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	5,135,026	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/29/2019 3:29 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,088	0	54.00
60.00	06000	LABORATORY	494,191	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,862	0	63.00
64.00	06400	INTRAVENOUS THERAPY	316,696	0	64.00
66.00	06600	PHYSICAL THERAPY	174,956	0	66.00
69.00	06900	ELECTROCARDIOLOGY	15,184	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,128	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,650	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	26,577	0	90.00
91.00	09100	EMERGENCY	566,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	180,092	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	2,217,684	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,217,684	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/29/2019 3:29 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199190	0	0	0	0	54.00
60.00	06000	LABORATORY	0.266173	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.228201	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.955154	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.505106	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.070429	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.551079	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.474736	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.053421	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.304788	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.846645	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.368281		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	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: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2017 To 08/31/2018	Worksheet D Part V Date/Time Prepared: 1/29/2019 3:29 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	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	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/29/2019 3:29 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,163	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		474	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)		352	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		121	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)		284	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		117	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)		167	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		241	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)		121	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)		195	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,136,145	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)		18,183	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)		25,953	25.00
26.00	Total swing-bed cost (see instructions)		1,008,032	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,128,113	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		1,128,113	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,379.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		573,578	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)		573,578	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/29/2019 3:29 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	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)				127,424	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				701,002	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)				287,979	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				464,098	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				752,077	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)				122	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				2,379.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				290,359	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1300		Period: From 09/01/2017 To 08/31/2018		Worksheet D-1 Date/Time Prepared: 1/29/2019 3:29 pm	
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	55,140	2,136,145	0.025813	290,359	7,495	90.00
91.00	Nursing School cost	0	2,136,145	0.000000	290,359	0	91.00
92.00	Allied health cost	0	2,136,145	0.000000	290,359	0	92.00
93.00	All other Medical Education	0	2,136,145	0.000000	290,359	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/29/2019 3:29 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		284,494		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.199190	44,753	8,914	54.00
60.00	06000 LABORATORY	0.266173	65,531	17,443	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.228201	1,888	431	63.00
64.00	06400 INTRAVENOUS THERAPY	0.955154	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.505106	18,303	9,245	66.00
69.00	06900 ELECTROCARDIOLOGY	0.070429	1,065	75	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.551079	86,815	47,842	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.474736	91,575	43,474	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.053421	0	0	90.00
91.00	09100 EMERGENCY	1.304788	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.846645	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)		309,930	127,424	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)		309,930		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2017 To 08/31/2018	Worksheet D-3 Date/Time Prepared: 1/29/2019 3:29 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.199190	8,588	1,711	54.00
60.00	06000 LABORATORY	0.266173	23,034	6,131	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.228201	944	215	63.00
64.00	06400 INTRAVENOUS THERAPY	0.955154	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.505106	103,073	52,063	66.00
69.00	06900 ELECTROCARDIOLOGY	0.070429	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.551079	72,946	40,199	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.474736	70,888	33,653	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.053421	0	0	90.00
91.00	09100 EMERGENCY	1.304788	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.846645	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)		279,473	133,972	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)		279,473		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/29/2019 3:29 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			2,217,684 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,217,684 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			2,239,861 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			20,504 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			646,083 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,573,274 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,573,274 30.00
31.00	Primary payer payments			1,340 31.00
32.00	Subtotal (line 30 minus line 31)			1,571,934 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			115,855 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			75,306 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			89,972 36.00
37.00	Subtotal (see instructions)			1,647,240 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)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,647,240 40.00
40.01	Sequestration adjustment (see instructions)			32,945 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			1,718,095 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-103,800 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 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		580,604		1,638,165	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	05/03/2018	105,122	05/03/2018	96,861	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	03/29/2018	61,652	03/29/2018	16,931	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)		43,470		79,930	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)		624,074		1,718,095	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		12,663		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		103,800	6.02	
7.00	Total Medicare program liability (see instructions)		636,737		1,614,295	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: 14-1300  
Component CCN: 14-Z300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/29/2019 3:29 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		793,693		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	05/03/2018	107,868		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	03/29/2018	65,509		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)		42,359		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)		836,052		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		27,447		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		863,499		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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet E-1 Part II Date/Time Prepared: 1/29/2019 3:29 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet E-2
		Component CCN: 14-Z300		Date/Time Prepared: 1/29/2019 3:29 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	759,598	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)	135,312	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	316	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)	894,910	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	894,910	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)	894,910	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,789	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)	881,121	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)	881,121	0	19.00
19.01	Sequestration adjustment (see instructions)	17,622	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	836,052	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)	27,447	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
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
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
<b>Cost Reimbursement</b>				
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
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
<b>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement</b>				
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
<b>Comparison of PPS versus Cost Reimbursement</b>				
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: 14-1300	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part V Date/Time Prepared: 1/29/2019 3:29 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			701,002 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)			701,002 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			708,012 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			708,012 19.00
20.00	Deductibles (exclude professional component)			74,464 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			633,548 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			633,548 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24,899 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			16,184 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			17,171 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			649,732 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)			649,732 30.00
30.01	Sequestration adjustment (see instructions)			12,995 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			624,074 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)			12,663 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet G

Date/Time Prepared:  
1/29/2019 3:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	300,597	0	0	0	1.00
2.00	Temporary investments	187,901	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,208,390	0	0	0	4.00
5.00	Other receivable	130,281	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,579,272	0	0	0	6.00
7.00	Inventory	30,633	0	0	0	7.00
8.00	Prepaid expenses	50,657	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,329,187	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	70,514	0	0	0	12.00
13.00	Land improvements	49,823	0	0	0	13.00
14.00	Accumulated depreciation	-36,371	0	0	0	14.00
15.00	Buildings	2,591,076	0	0	0	15.00
16.00	Accumulated depreciation	-2,425,307	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	84,028	0	0	0	19.00
20.00	Accumulated depreciation	-82,839	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	3,603,953	0	0	0	23.00
24.00	Accumulated depreciation	-3,128,043	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	7,644	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	734,478	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	32,830	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,830	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,096,495	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,793,450	0	0	0	37.00
38.00	Salaries, wages, and fees payable	660,714	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	84,317	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,610	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,548,091	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	620,080	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)	620,080	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,168,171	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-1,071,676				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)	-1,071,676	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,096,495	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet G-1

Date/Time Prepared:  
1/29/2019 3:29 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		-1,659,910		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		640,762				2.00
3.00	Total (sum of line 1 and line 2)		-1,019,148		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)		-1,019,148		0		11.00
12.00	RESTRICTED ASSETS CHANGE	52,528		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)		52,528		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,071,676		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	RESTRICTED ASSETS CHANGE		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: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
1/29/2019 3:29 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	243,465		243,465	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	280,027		280,027	5.00
6.00	Swing bed - NF	196,528		196,528	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	720,020		720,020	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	720,020		720,020	17.00
18.00	Ancillary services	902,242	10,991,733	11,893,975	18.00
19.00	Outpatient services	1,896	1,535,332	1,537,228	19.00
20.00	RURAL HEALTH CLINIC	0	2,492,014	2,492,014	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,713,676	1,713,676	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	168,581	884,639	1,053,220	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,792,739	17,617,394	19,410,133	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,179,663		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)		12,179,663		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1300

Period:  
From 09/01/2017  
To 08/31/2018

Worksheet G-3

Date/Time Prepared:  
1/29/2019 3:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	19,410,133	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,830,962	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,579,171	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,179,663	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-600,492	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	179,716	6.00
7.00	Income from investments	44,158	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	33,163	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,268	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	3,999	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	22,300	22.00
23.00	Governmental appropriations	84,373	23.00
24.00	AMBULANCE	353,196	24.00
24.01	WELLNESS CENTER	11,103	24.01
24.02	HEALTH FAIR	7,410	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	4,536	24.03
24.04	OTHER MISC INCOME	52,129	24.04
24.05	VENDOR DEBT FORGIVENESS	381,990	24.05
24.06	PT CONSULTING SERVICES	57,913	24.06
25.00	Total other income (sum of lines 6-24)	1,241,254	25.00
26.00	Total (line 5 plus line 25)	640,762	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)	640,762	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1300 Component CCN: 14-3403		Period: From 09/01/2017 To 08/31/2018		Worksheet M-1 Date/Time Prepared: 1/29/2019 3:29 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	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	470,400	28,275	498,675	0	498,675	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	505,448	29,132	534,580	0	534,580	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	225,000	14,343	239,343	0	239,343	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	146,325	8,305	154,630	0	154,630	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,347,173	80,055	1,427,228	0	1,427,228	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	1,966	1,966	0	1,966	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	1,966	1,966	0	1,966	14.00
15.00	Medical Supplies	0	58,235	58,235	0	58,235	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	115,574	115,574	-59,369	56,205	18.00
19.00	Other Health Care Costs	0	0	0	11,063	11,063	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	173,809	173,809	-48,306	125,503	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,347,173	255,830	1,603,003	-48,306	1,554,697	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	81,667	81,667	-4,846	76,821	29.00
30.00	Administrative Costs	182,520	62,167	244,687	-266,548	-21,861	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	182,520	143,834	326,354	-271,394	54,960	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,529,693	399,664	1,929,357	-319,700	1,609,657	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300

Period: From 09/01/2017

Worksheet M-1

Component CCN: 14-3403

To 08/31/2018

Date/Time Prepared: 1/29/2019 3:29 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	498,675	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	534,580	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	239,343	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	154,630	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,427,228	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	1,966	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,966	14.00
15.00	Medical Supplies	0	58,235	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	56,205	18.00
19.00	Other Health Care Costs	0	11,063	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	125,503	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,554,697	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
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
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	76,821	29.00
30.00	Administrative Costs	0	-21,861	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	54,960	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,609,657	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2017 To 08/31/2018	Worksheet M-2 Date/Time Prepared: 1/29/2019 3:29 pm
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		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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	1.67	4,690	4,200	7,014	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	4.34	10,312	2,100	9,114	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.01	15,002		16,128	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)	6.01	15,002		16,128	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES</b>			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,554,697
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,554,697
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)		54,960
15.00	Parent provider overhead allocated to facility (see instructions)		747,556
16.00	Total overhead (sum of lines 14 and 15)		802,516
17.00	Allowable GME overhead (see instructions)		0
18.00	Enter the amount from line 16		802,516
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)		802,516
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)		2,357,213

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2017 To 08/31/2018	Worksheet M-3 Date/Time Prepared: 1/29/2019 3:29 pm	
		Title XVIII	RHC I	Cost	
				1.00	
<b>DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES</b>					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,357,213	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			36,713	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,320,500	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,128	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)			16,128	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			143.88	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)		143.88	143.88	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,057	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	583,721	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	583,721	16.00
16.01	Total program charges (see instructions)(from contractor's records)			661,006	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			21,640	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			19,110	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.)			382,738	16.04
16.05	Total program cost (see instructions)		0	401,848	16.05
17.00	Primary payer amounts			190	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			86,188	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			110,636	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			401,658	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			26,090	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			427,748	22.00
23.00	Allowable bad debts (see instructions)			33,771	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			21,951	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29,615	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)			449,699	26.00
26.01	Sequestration adjustment (see instructions)			8,994	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			363,343	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)			77,362	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2017 To 08/31/2018	Worksheet M-4 Date/Time Prepared: 1/29/2019 3:29 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,427,228	1,427,228	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000334	0.000903	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		477	1,289	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		16,851	5,597	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		17,328	6,886	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,554,697	1,554,697	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		802,516	802,516	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.011146	0.004429	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,945	3,554	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		26,273	10,440	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		131	354	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		200.56	29.49	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		107	157	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		21,460	4,630	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			36,713	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			26,090	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2017 To 08/31/2018	Worksheet M-5 Date/Time Prepared: 1/29/2019 3:29 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		348,001	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		03/29/2018	23,770	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		05/03/2018	8,428	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)		15,342	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		363,343	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		77,362	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		440,705	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00