

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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/16/2018 12:33 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/16/2018 Time: 12:33 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - ALEDO (14-1304) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____ ADMINISTRATOR, GMC ALEDO
Title

_____ 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	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,181	19,864	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	10,290	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		60,049		0	10.00
200.00 Total	0	11,471	79,913	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:09 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 409 N.W. NINTH AVENUE			PO Box:						1.00
2.00	City: ALEDO			State: IL		Zip Code: 61231-		County: MERCER		2.00
		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	GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	19340		05/01/2000	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GENESIS MEDICAL CENTER - ALEDO, RHC	143453	19340		02/29/2000	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2017		06/30/2018		20.00
21.00	Type of Control (see instructions)					2				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							0		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
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

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		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.		0			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.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N		0.00	0.00
61.01	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

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
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.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
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)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
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	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0 76.00	

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				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	Y	N	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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:09 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	15,845	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		H55790		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:09 am				
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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH		Contractor's Number: 05001				141.00		
142.00	Street: 1227 E RUSHOLME STREET	PO Box:						142.00		
143.00	City: DAVENPORT	State: IA		Zip Code: 52803				143.00		
1.00										
144.00	Are provider based physicians' costs included in Worksheet A?						Y		144.00	
1.00										
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00	
1.00										
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N		149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		155.00		
156.00	Subprovider - IPF	N		N		N		156.00		
157.00	Subprovider - IRF	N		N		N		157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N		N		N		159.00		
160.00	HOME HEALTH AGENCY	N		N		N		160.00		
161.00	CMHC	N		N		N		161.00		
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)						0		168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00		169.00	
						Begining	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						01/01/2017 03/31/2017		170.00	
1.00										
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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/16/2018 9:09 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	09/12/2018	Y	09/12/2018
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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/16/2018 9:09 am	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			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: 14-1304

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

Worksheet S-2
Part II
Date/Time Prepared:
11/16/2018 9:09 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR, REI MBURSEMENT	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: 14-1304

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

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2018 9:09 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	9,648.00	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)		22	8,030	9,648.00	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)		22	8,030	9,648.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1304

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

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2018 9:09 am

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)	242	7	402			1.00
2.00 HMO and other (see instructions)	87	20				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	468	0	678			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	62			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	710	7	1,142			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)	710	7	1,142	0.00	77.81	14.00
15.00 CAH visits	5,757	685	18,638			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	4,933	6,130	24,011	0.00	21.23	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	99.04	27.00
28.00 Observation Bed Days		4	293			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: 14-1304

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

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2018 9:09 am

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	72	3	120	1.00
2.00 HMO and other (see instructions)				23	10		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	72	3		120	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1304 Component CCN: 14-3453		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/16/2018 9:09 am	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		1007 NW 3RD STREET		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		ALEDO IL 61231		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				1.00		2.00	
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		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	11.00	Facility hours of operations (1) CLINIC		07:00 18:00		08:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
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.		N		0	
		Provider name		CCN number			
		1.00		2.00			
14.00	14.00	RHC/FQHC name, CCN number				Total Visits	
		Y/N		V			
		1.00		2.00		3.00 4.00 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)					
		County		4.00			
2.00	2.00	City, State, ZIP Code, County		MERCER		2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	11.00	Facility hours of operations (1) CLINIC		17:00 08:00		17:00 08:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1304 Component CCN: 14-3453		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/16/2018 9:09 am	
				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	18:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/16/2018 9:09 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.514919	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,035,841	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		172,022	5.00	
6.00	Medicaid charges		4,341,268	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,235,401	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)		1,027,538	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		5,415	9.00	
10.00	Stand-alone CHIP charges		12,480	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		6,426	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		1,011	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)		1,028,549	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)	353,485	0	353,485	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	182,016	0	182,016	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)	182,016	0	182,016	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)		722,221	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		95,944	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		147,606	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		574,615	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		347,542	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		529,558	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,558,107	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet A		
Date/Time Prepared: 11/16/2018 9:09 am								
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		839,777	839,777	29,337	869,114	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		306,137	306,137	210	306,347	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,059	648,464	664,523	0	664,523	4.00
5.01	00570	ADMINISTRATIVE	118,537	12,094	130,631	0	130,631	5.01
5.02	00590	HOSPITAL ONLY A & G	0	168,478	168,478	0	168,478	5.02
5.03	00591	SHARED ADMIN & GENERAL	303,435	2,421,227	2,724,662	197,787	2,922,449	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	564,127	564,127	11,745	575,872	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,909	1,963	27,872	0	27,872	8.00
9.00	00900	HOUSEKEEPING	0	156,166	156,166	0	156,166	9.00
10.00	01000	DIETARY	0	163,887	163,887	0	163,887	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,761	41,254	58,015	0	58,015	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	58,887	5,418	64,305	0	64,305	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	323,652	323,652	-151,142	172,510	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	876,402	206,130	1,082,532	-13,641	1,068,891	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	150,062	120,073	270,135	-31,516	238,619	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	454,849	358,511	813,360	-6,301	807,059	54.00
60.00	06000	LABORATORY	434,224	578,998	1,013,222	-27,003	986,219	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	27,003	27,003	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	210,079	54,915	264,994	-11,900	253,094	65.00
66.00	06600	PHYSICAL THERAPY	293,414	108,295	401,709	0	401,709	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	67,449	67,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,570	3,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,208	559,047	809,255	-313,642	495,613	73.00
76.00	03950	SLEEP LAB	20,951	6,910	27,861	-786	27,075	76.00
76.01	03951	DIABETIC EDUCATION	1,767	147	1,914	0	1,914	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,250,850	450,707	2,701,557	-239,079	2,462,478	88.00
91.00	09100	EMERGENCY	758,777	1,500,632	2,259,409	-6,875	2,252,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		345,434	345,434	0	345,434	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,241,171	9,942,443	16,183,614	-464,784	15,718,830	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	383,519	137,626	521,145	151,142	672,287	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	313,642	313,642	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	6,624,690	10,080,069	16,704,759	0	16,704,759	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1304

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

Worksheet A
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	869,114	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,306	303,041	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-138,152	526,371	4.00
5.01	00570	ADMINISTRATIVE	0	130,631	5.01
5.02	00590	HOSPITAL ONLY A & G	10,271	178,749	5.02
5.03	00591	SHARED ADMN & GENERAL	-349,205	2,573,244	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	575,872	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,872	8.00
9.00	00900	HOUSEKEEPING	0	156,166	9.00
10.00	01000	DIETARY	0	163,887	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	143,796	143,796	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,655	72,670	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156,294	156,294	16.00
17.00	01700	SOCIAL SERVICE	0	64,305	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	172,510	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,068,891	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	238,619	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-687	806,372	54.00
60.00	06000	LABORATORY	0	986,219	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	27,003	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-17,435	235,659	65.00
66.00	06600	PHYSICAL THERAPY	-4,757	396,952	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	495,613	73.00
76.00	03950	SLEEP LAB	0	27,075	76.00
76.01	03951	DIABETIC EDUCATION	0	1,914	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-4,131	2,458,347	88.00
91.00	09100	EMERGENCY	-161,961	2,090,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-345,434	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-700,052	15,018,778	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-826	671,461	192.00
194.00	07950	RETAIL PHARMACY	0	313,642	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-700,878	16,003,881	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	212,947	14,387	1.00
	O		212,947	14,387	
B - BLOOD					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	4,816	22,187	1.00
	O		4,816	22,187	
C - COST OF IMPLANTS & SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,570	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	71,019	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	O		0	74,589	
D - RETAIL PHARMACY					
1.00	RETAIL PHARMACY	194.00	99,216	214,426	1.00
	O		99,216	214,426	
E - CRNA CLINIC SERVICES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	151,142	1.00
	O		0	151,142	
F - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	29,547	1.00
	O		0	29,547	
G - UTILITIES					
1.00	MAINTENANCE & REPAIRS	6.00	0	11,745	1.00
	TOTALS		0	11,745	
500.00	Grand Total: Increases		316,979	518,023	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RHC SALARY							
1.00	RURAL HEALTH CLINIC	88.00	212,947	14,387	0		1.00
	O		212,947	14,387			
B - BLOOD							
1.00	LABORATORY	60.00	4,816	22,187	0		1.00
	O		4,816	22,187			
C - COST OF IMPLANTS & SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,570	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	13,641	0		2.00
3.00	OPERATING ROOM	50.00	0	31,516	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,301	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	11,900	0		5.00
6.00	SLEEP LAB	76.00	0	786	0		6.00
7.00	EMERGENCY	91.00	0	6,875	0		7.00
	O		0	74,589			
D - RETAIL PHARMACY							
1.00	DRUGS CHARGED TO PATIENTS	73.00	99,216	214,426	0		1.00
	O		99,216	214,426			
E - CRNA CLINIC SERVICES							
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	151,142	0		1.00
	O		0	151,142			
F - PROPERTY INSURANCE							
1.00	SHARED ADMN & GENERAL	5.03	0	29,547	11		1.00
	O		0	29,547			
G - UTILITIES							
1.00	RURAL HEALTH CLINIC	88.00	0	11,745	0		1.00
	TOTALS		0	11,745			
500.00	Grand Total: Decreases		316,979	518,023			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

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

Worksheet A-7
Part I
Date/Time Prepared:
11/16/2018 9:09 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	326,018	850	0	850	0	2.00
3.00	Buildings and Fixtures	12,426,073	220,775	0	220,775	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,169,037	132,704	0	132,704	0	5.00
6.00	Movable Equipment	109,793	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,095,921	354,329	0	354,329	0	8.00
9.00	Reconciling Items	-775,441	-310,278	0	-310,278	0	9.00
10.00	Total (line 8 minus line 9)	15,871,362	664,607	0	664,607	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0				1.00
2.00	Land Improvements	326,868	0				2.00
3.00	Buildings and Fixtures	12,646,848	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,301,741	0				5.00
6.00	Movable Equipment	109,793	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	15,450,250	0				8.00
9.00	Reconciling Items	-1,085,719	0				9.00
10.00	Total (line 8 minus line 9)	16,535,969	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

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

Worksheet A-7
Part II
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	839,777	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	306,137	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,145,914	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	839,777				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	306,137				2.00
3.00	Total (sum of lines 1-2)	0	1,145,914				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

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

Worksheet A-7
Part III
Date/Time Prepared:
11/16/2018 9:09 am

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	CAP REL COSTS-BLDG & FIXT	15,340,457	0	15,340,457	0.992894	29,337	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.007106	210	2.00
3.00	Total (sum of lines 1-2)	15,450,250	0	15,450,250	1.000000	29,547	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	29,337	839,777	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	210	302,831	0	2.00
3.00	Total (sum of lines 1-2)	0	0	29,547	1,142,608	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	29,337	0	0	869,114	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	210	0	0	303,041	2.00
3.00	Total (sum of lines 1-2)	0	29,547	0	0	1,172,155	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7	Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-69		SHARED ADMN & GENERAL	5.03		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	-3,219		CAP REL COSTS-MVBLE EQUIP	2.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-178,830					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	-130,779					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		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			0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-65,440		SHARED ADMN & GENERAL	5.03		0	32.00
33.00 MISC INCOME - RHC	B	-1,500		RURAL HEALTH CLINIC	88.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/16/2018 9:09 am

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	
33.01 PATIENT PHONES - DEPRECIATION	A	-87	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.01
33.02 PATIENT PHONES - SALARY	A	-1,160	RURAL HEALTH CLINIC	88.00	0 33.02
33.03 PATIENT PHONES - BENEFITS	A	-116	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.03
33.04 ADVERTISING	A	-6,850	SHARED ADMN & GENERAL	5.03	0 33.04
33.05 ADVERTISING	A	-687	RADIOLOGY-DIAGNOSTIC	54.00	0 33.05
33.06 ADVERTISING	A	-4,757	PHYSICAL THERAPY	66.00	0 33.06
33.07 ADVERTISING	A	-1,471	RURAL HEALTH CLINIC	88.00	0 33.07
33.08 ADVERTISING	A	-566	EMERGENCY	91.00	0 33.08
33.09 ADVERTISING	A	-826	PHYSICIANS' PRIVATE OFFICES	192.00	0 33.09
33.10 PROVIDER TAX ASSESSMENT	A	-143,341	SHARED ADMN & GENERAL	5.03	0 33.10
33.11 LOBBYING PORTION OF DUES	A	-7,391	SHARED ADMN & GENERAL	5.03	0 33.11
33.12 EMPLOYEE HEALTH INSURANCE	A	-138,036	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.12
33.13 LEGAL FEES (CHOW) - AMORTIZED	A	54,499	SHARED ADMN & GENERAL	5.03	0 33.13
34.00 PHYSICIAN PRACTICE OVERHEAD	A	-70,252	SHARED ADMN & GENERAL	5.03	0 34.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-700,878			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 14-1304
 Period: From 07/01/2017 To 06/30/2018
 Worksheet A-8-1
 Date/Time Prepared: 11/16/2018 9:09 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - ADMIN	4,308	0
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - IT	170,732	705,406
3.00	5.02	HOSPITAL ONLY A & G	HOME OFFICE - SBS PATIENT AC	178,665	168,394
4.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - SBS PATIENT AC	170,228	0
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE - TRANSCRIPTION	156,294	0
4.02	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE - CENTRAL SUPPLY	14,655	0
4.03	5.03	SHARED ADMN & GENERAL	HOME OFFICE - MEDICAL AFFAIR	25,391	0
4.04	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PAYOR CONTRACT	8,770	0
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE - CARE COORDINAT	143,796	0
4.06	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PHYSICIAN RECR	11,763	0
4.10	5.03	SHARED ADMN & GENERAL	HOME OFFICE - LIBRARY	6,231	0
4.11	5.03	SHARED ADMN & GENERAL	HOME OFFICE - AFFILIATE FACI	217,332	0
4.12	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - CAPITAL	284,697	0
4.13	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - NON-CAP	945,969	1,250,376
4.14	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	14,368	14,368
4.15	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	16,747	16,747
4.16	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	3,079	3,079
4.17	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	2,860	2,860
4.18	60.00	LABORATORY	VARIOUS SERVICES - RELATED	69,731	69,731
4.19	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	4,200	4,200
4.20	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	1,590	1,590
4.21	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	22,857	22,857
4.22	76.00	SLEEP LAB	VARIOUS SERVICES - RELATED	5	5
4.24	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	1,336	1,336
4.25	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	13,714	13,714
4.26	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS SERVICES - RELATED	2,673	2,673
4.27	194.00	RETAIL PHARMACY	VARIOUS SERVICES - RELATED	49,207	49,207
4.28	113.00	INTEREST EXPENSE	INTEREST EXPENSE - RELATED	0	345,434
4.29	88.00	RURAL HEALTH CLINIC	GHG - MGMT FEE	125,667	125,667
4.30	192.00	PHYSICIANS' PRIVATE OFFICES	GHG - MGMT FEE	24,546	24,546
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,691,411	2,822,190

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

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

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

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

6.00	B	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/16/2018 9:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	4,308	9	1.00
2.00	-534,674	0	2.00
3.00	10,271	0	3.00
4.00	170,228	0	4.00
4.01	156,294	0	4.01
4.02	14,655	0	4.02
4.03	25,391	0	4.03
4.04	8,770	0	4.04
4.05	143,796	0	4.05
4.06	11,763	0	4.06
4.10	6,231	0	4.10
4.11	217,332	0	4.11
4.12	284,697	0	4.12
4.13	-304,407	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
4.21	0	0	4.21
4.22	0	0	4.22
4.24	0	0	4.24
4.25	0	0	4.25
4.26	0	0	4.26
4.27	0	0	4.27
4.28	-345,434	0	4.28
4.29	0	0	4.29
4.30	0	0	4.30
5.00	-130,779		5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1304

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

Worksheet A-8-2

Date/Time Prepared:
11/16/2018 9:09 am

	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	65.00	RESPIRATORY THERAPY	17,435	17,435	0	0	0	1.00
2.00	91.00	EMERGENCY	1,337,683	161,395	1,176,288	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,355,118	178,830	1,176,288	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	65.00	RESPIRATORY THERAPY	0	0	0	17,435	1.00
2.00	91.00	EMERGENCY	0	0	0	161,395	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	178,830	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/16/2018 9:09 am	
				Occupational Therapy		Cost	
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					48	1.00
2.00	Line 1 multiplied by 15 hours per week					720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					218	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	1,145.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	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)	38.31	38.31	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			
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					87,718	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)					87,718	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)					87,718	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)					87,718	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					8,352	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)					8,352	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,177	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,529	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,529	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/16/2018 9:09 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					87,718	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					9,529	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)					97,247	63.00
64.00	Total cost of outside supplier services (from your records)					52,870	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					8,352	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,177	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					9,529	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,177	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,177	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

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

Worksheet B
Part I
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	869,114	869,114			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	303,041		303,041		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	526,371	0	0	526,371	4.00
5.01 00570	ADMITTING	130,631	0	1,645	9,443	141,719 5.01
5.02 00590	HOSPITAL ONLY A & G	178,749	1,020	0	0	0 5.02
5.03 00591	SHARED ADMN & GENERAL	2,573,244	175,093	19,868	41,137	0 5.03
6.00 00600	MAINTENANCE & REPAIRS	575,872	79,860	12,623	0	0 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	27,872	2,368	0	2,064	0 8.00
9.00 00900	HOUSEKEEPING	156,166	11,440	0	0	0 9.00
10.00 01000	DIETARY	163,887	36,214	4,965	0	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	143,796	1,840	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	72,670	30,512	4,406	1,335	0 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	156,294	3,971	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	64,305	2,732	0	4,691	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	172,510	1,020	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,068,891	168,901	17,362	69,817	11,756 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	238,619	92,210	52,703	11,954	9,711 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	806,372	79,332	147,101	36,235	40,211 54.00
60.00 06000	LABORATORY	986,219	30,858	1,872	34,208	31,830 60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	27,003	0	0	384	357 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	235,659	5,793	7,237	16,736	4,036 65.00
66.00 06600	PHYSICAL THERAPY	396,952	43,264	12,284	23,374	9,122 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,449	0	0	0	2,198 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,570	0	0	0	80 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	495,613	10,784	284	12,028	9,846 73.00
76.00 03950	SLEEP LAB	27,075	15,393	2,733	1,669	1,941 76.00
76.01 03951	DIABETIC EDUCATION	1,914	0	0	141	20 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	2,458,347	0	537	162,253	0 88.00
91.00 09100	EMERGENCY	2,090,573	43,209	11,800	60,446	20,611 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15,018,778	835,814	297,420	487,915	141,719 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,682	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	671,461	0	4,188	30,552	0 192.00
194.00 07950	RETAIL PHARMACY	313,642	0	1,433	7,904	0 194.00
194.01 07951	NONPATIENT RELATED MEALS	0	0	0	0	0 194.01
194.02 07952	KIDNEY CENTER	0	28,618	0	0	0 194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	16,003,881	869,114	303,041	526,371	141,719 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

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

Worksheet B
Part I
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description			Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			5A.01	5.02	5A.02	5.03	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00590	HOSPITAL ONLY A & G	179,769	179,769				5.02
5.03	00591	SHARED ADMN & GENERAL	2,809,342	41,604	2,850,946	2,850,946		5.03
6.00	00600	MAINTENANCE & REPAIRS	668,355	9,896	678,251	147,334	825,585	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,304	478	32,782	7,121	2,749	8.00
9.00	00900	HOUSEKEEPING	167,606	2,482	170,088	36,948	13,282	9.00
10.00	01000	DIETARY	205,066	3,036	208,102	45,205	42,046	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	145,636	2,156	147,792	32,104	2,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,923	1,613	110,536	24,011	35,426	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,265	2,373	162,638	35,329	4,611	16.00
17.00	01700	SOCIAL SERVICE	71,728	1,062	72,790	15,812	3,172	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	173,530	2,569	176,099	38,253	1,184	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,336,727	19,793	1,356,520	294,671	196,101	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	405,197	6,000	411,197	89,323	107,061	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,251	16,425	1,125,676	244,526	92,108	54.00
60.00	06000	LABORATORY	1,084,987	16,065	1,101,052	239,177	35,828	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	27,744	411	28,155	6,116	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	269,461	3,990	273,451	59,401	6,726	65.00
66.00	06600	PHYSICAL THERAPY	484,996	7,181	492,177	106,914	50,231	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,647	1,031	70,678	15,353	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,650	54	3,704	805	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	528,555	7,826	536,381	116,516	12,521	73.00
76.00	03950	SLEEP LAB	48,811	723	49,534	10,760	17,872	76.00
76.01	03951	DIABETIC EDUCATION	2,075	31	2,106	457	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,621,137	0	2,621,137	569,383	113,702	88.00
91.00	09100	EMERGENCY	2,226,639	32,970	2,259,609	490,846	50,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,941,401	179,769	14,941,401	2,626,365	786,923	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,682	0	4,682	1,017	5,436	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	706,201	0	706,201	153,405	0	192.00
194.00	07950	RETAIL PHARMACY	322,979	0	322,979	70,159	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	28,618	0	28,618	0	33,226	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,003,881	179,769	16,003,881	2,850,946	825,585	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/16/2018 9:09 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,652				8.00
9.00	00900	HOUSEKEEPING	0	220,318			9.00
10.00	01000	DIETARY	0	11,443	306,796		10.00
11.00	01100	CAFETERIA	0	0	239,812	239,812	11.00
13.00	01300	NURSING ADMINISTRATION	0	581	0	182,613	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,641	0	1,239	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,255	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	863	0	3,002	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	322	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,425	53,371	66,984	44,756	99,324
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,106	29,136	0	6,858	13,032
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,818	25,067	0	19,500	170
60.00	06000	LABORATORY	0	9,750	0	26,826	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	193	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,830	0	9,089	90
66.00	06600	PHYSICAL THERAPY	1,660	13,670	0	13,441	13
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,407	0	3,608	0
76.00	03950	SLEEP LAB	7	4,864	0	1,019	0
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	293	30,944	0	59,575	0
91.00	09100	EMERGENCY	12,343	13,653	0	31,288	69,984
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,652	209,797	306,796	220,394	182,613
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,479	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	17,049	0
194.00	07950	RETAIL PHARMACY	0	0	0	2,369	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0
194.02	07952	KIDNEY CENTER	0	9,042	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	42,652	220,318	306,796	239,812	182,613

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

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

Worksheet B
Part I
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570						5.01
5.02	00590						5.02
5.03	00591						5.03
6.00	00600						6.00
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	180,853					14.00
16.00	01600	0	203,833				16.00
17.00	01700	0	0	95,639			17.00
19.00	01900	0	0	0	215,858		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,775	16,909	95,639	0	2,273,475	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,009	13,968	0	215,858	907,548	50.00
54.00	05400	24,932	57,828	0	0	1,593,625	54.00
60.00	06000	1,490	45,783	0	0	1,459,906	60.00
63.00	06300	0	513	0	0	34,977	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,322	5,806	0	0	357,715	65.00
66.00	06600	5,000	13,121	0	0	696,227	66.00
71.00	07100	52,731	3,161	0	0	141,923	71.00
72.00	07200	2,791	115	0	0	7,415	72.00
73.00	07300	4,011	14,163	0	0	690,607	73.00
76.00	03950	2,708	2,792	0	0	89,556	76.00
76.01	03951	0	28	0	0	2,591	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	12,906	0	0	0	3,407,940	88.00
91.00	09100	21,175	29,646	0	0	2,978,711	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		174,850	203,833	95,639	215,858	14,642,216	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	12,614	190.00
192.00	19200	6,003	0	0	0	882,658	192.00
194.00	07950	0	0	0	0	395,507	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	70,886	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		180,853	203,833	95,639	215,858	16,003,881	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	HOSPITAL ONLY A & G		5.02
5.03	00591	SHARED ADMN & GENERAL		5.03
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-190,478	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	25,989	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	164,489	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	SLEEP LAB	0	76.00
76.01	03951	DIABETIC EDUCATION	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	RETAIL PHARMACY	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	194.01
194.02	07952	KIDNEY CENTER	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/16/2018 9:09 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01 00570	ADMINISTRATIVE	0	0	1,645	1,645	5.01
5.02 00590	HOSPITAL ONLY A & G	0	1,020	0	1,020	5.02
5.03 00591	SHARED ADMN & GENERAL	246,588	175,093	19,868	441,549	5.03
6.00 00600	MAINTENANCE & REPAIRS	1,056	79,860	12,623	93,539	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,368	0	2,368	8.00
9.00 00900	HOUSEKEEPING	0	11,440	0	11,440	9.00
10.00 01000	DIETARY	2,588	36,214	4,965	43,767	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,840	0	1,840	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	30,512	4,406	34,918	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,971	0	3,971	16.00
17.00 01700	SOCIAL SERVICE	0	2,732	0	2,732	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	1,020	0	1,020	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	168,901	17,362	186,263	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	92,210	52,703	144,913	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	79,332	147,101	226,433	54.00
60.00 06000	LABORATORY	0	30,858	1,872	32,730	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
65.00 06500	RESPIRATORY THERAPY	124	5,793	7,237	13,154	65.00
66.00 06600	PHYSICAL THERAPY	0	43,264	12,284	55,548	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	10,784	284	11,068	73.00
76.00 03950	SLEEP LAB	0	15,393	2,733	18,126	76.00
76.01 03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	68,047	0	537	68,584	88.00
91.00 09100	EMERGENCY	0	43,209	11,800	55,009	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	318,403	835,814	297,420	1,451,637	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,682	0	4,682	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	27,999	0	4,188	32,187	192.00
194.00 07950	RETAIL PHARMACY	0	0	1,433	1,433	194.00
194.01 07951	NONPATIENT RELATED MEALS	0	0	0	0	194.01
194.02 07952	KIDNEY CENTER	0	28,618	0	28,618	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	346,402	869,114	303,041	1,518,557	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/16/2018 9:09 am	
Cost Center Description			ADMINISTRATIVE	HOSPITAL ONLY A & G	SHARED ADMIN & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	6.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE	1,645					5.01
5.02	00590	HOSPITAL ONLY A & G	0	1,020				5.02
5.03	00591	SHARED ADMIN & GENERAL	0	238	441,787			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	56	22,831	116,426		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3	1,104	388	3,863	8.00
9.00	00900	HOUSEKEEPING	0	14	5,726	1,873	0	9.00
10.00	01000	DIETARY	0	17	7,005	5,929	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12	4,975	301	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9	3,721	4,996	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	5,475	650	0	16.00
17.00	01700	SOCIAL SERVICE	0	6	2,450	447	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	15	5,928	167	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136	112	45,663	27,655	1,940	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112	34	13,842	15,098	281	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473	93	37,893	12,989	346	54.00
60.00	06000	LABORATORY	368	91	37,064	5,053	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4	2	948	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	47	23	9,205	948	0	65.00
66.00	06600	PHYSICAL THERAPY	105	41	16,568	7,084	150	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25	6	2,379	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1	0	125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114	44	18,056	1,766	0	73.00
76.00	03950	SLEEP LAB	22	4	1,667	2,520	1	76.00
76.01	03951	DIABETIC EDUCATION	0	0	71	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	88,226	16,034	27	88.00
91.00	09100	EMERGENCY	238	187	76,063	7,075	1,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,645	1,020	406,985	110,973	3,863	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	158	767	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	23,772	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	10,872	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	4,686	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,645	1,020	441,787	116,426	3,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/16/2018 9:09 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	19,053					9.00
10.00	01000	DIETARY	990	57,708				10.00
11.00	01100	CAFETERIA	0	45,108	45,108			11.00
13.00	01300	NURSING ADMINISTRATION	50	0	0	7,178		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	834	0	233	0	44,711	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	75	0	565	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	28	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,613	12,600	8,419	3,903	6,867	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,520	0	1,290	512	4,452	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,168	0	3,668	7	6,164	54.00
60.00	06000	LABORATORY	843	0	5,046	0	368	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	36	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	158	0	1,710	4	327	65.00
66.00	06600	PHYSICAL THERAPY	1,182	0	2,528	1	1,236	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	295	0	679	0	992	73.00
76.00	03950	SLEEP LAB	421	0	192	0	670	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,676	0	11,204	0	3,191	88.00
91.00	09100	EMERGENCY	1,181	0	5,885	2,751	5,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,143	57,708	41,455	7,178	43,227	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	128	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,207	0	1,484	192.00
194.00	07950	RETAIL PHARMACY	0	0	446	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	782	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,053	57,708	45,108	7,178	44,711	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/16/2018 9:09 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,218					16.00
17.00	01700	SOCIAL SERVICE	0	6,275				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	7,158			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	847	6,275		305,293	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	700	0		183,754	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,904	0		293,138	0	54.00
60.00	06000	LABORATORY	2,294	0		83,857	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	26	0		1,016	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	291	0		25,867	0	65.00
66.00	06600	PHYSICAL THERAPY	657	0		85,100	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158	0		15,603	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6	0		822	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	709	0		33,723	0	73.00
76.00	03950	SLEEP LAB	140	0		23,763	0	76.00
76.01	03951	DIABETIC EDUCATION	1	0		72	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		189,942	0	88.00
91.00	09100	EMERGENCY	1,485	0		156,227	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,218	6,275	0	1,398,177	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		5,735	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		60,650	0	192.00
194.00	07950	RETAIL PHARMACY	0	0		12,751	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		0	0	194.01
194.02	07952	KIDNEY CENTER	0	0		34,086	0	194.02
200.00		Cross Foot Adjustments			7,158	7,158	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,218	6,275	7,158	1,518,557	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

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

Worksheet B
Part II
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00570	ADMITTING	5.01
5.02	00590	HOSPITAL ONLY A & G	5.02
5.03	00591	SHARED ADMN & GENERAL	5.03
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	SLEEP LAB	76.00
76.01	03951	DIABETIC EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	RETAIL PHARMACY	194.00
194.01	07951	NONPATIENT RELATED MEALS	194.01
194.02	07952	KIDNEY CENTER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	47,711				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		302,829			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,607,471		4.00
5.01 00570	ADMITTING	0	1,644	118,537	23,050,872	5.01
5.02 00590	HOSPITAL ONLY A & G	56	0	0	0	-179,769 5.02
5.03 00591	SHARED ADMN & GENERAL	9,612	19,854	516,382	0	0 5.03
6.00 00600	MAINTENANCE & REPAIRS	4,384	12,614	0	0	0 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	130	0	25,909	0	0 8.00
9.00 00900	HOUSEKEEPING	628	0	0	0	0 9.00
10.00 01000	DIETARY	1,988	4,962	0	0	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	101	0	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,675	4,403	16,761	0	0 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	150	0	58,887	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,272	17,350	876,402	1,912,113	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,062	52,666	150,062	1,579,589	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,355	146,997	454,849	6,539,912	0 54.00
60.00 06000	LABORATORY	1,694	1,871	429,408	5,177,336	0 60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	4,816	58,061	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	318	7,232	210,079	656,552	0 65.00
66.00 06600	PHYSICAL THERAPY	2,375	12,275	293,414	1,483,763	0 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	357,512	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,993	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	592	284	150,992	1,601,562	0 73.00
76.00 03950	SLEEP LAB	845	2,731	20,951	315,758	0 76.00
76.01 03951	DIABETIC EDUCATION	0	0	1,767	3,210	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	537	2,036,743	0	-2,621,137 88.00
91.00 09100	EMERGENCY	2,372	11,792	758,777	3,352,511	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	45,883	297,212	6,124,736	23,050,872	-2,800,906 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	-4,682 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	4,185	383,519	0	-706,201 192.00
194.00 07950	RETAIL PHARMACY	0	1,432	99,216	0	-322,979 194.00
194.01 07951	NONPATIENT RELATED MEALS	0	0	0	0	0 194.01
194.02 07952	KIDNEY CENTER	1,571	0	0	0	-28,618 194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	869,114	303,041	526,371	141,719	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.216218	1.000700	0.079663	0.006148	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	1,645	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000071	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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5A.03	5.03	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMINITTING					5.01
5.02	00590	HOSPITAL ONLY A & G	12,140,495				5.02
5.03	00591	SHARED ADMN & GENERAL	2,809,342	-2,850,946	13,124,317		5.03
6.00	00600	MAINTENANCE & REPAIRS	668,355	0	678,251	39,035	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,304	0	32,782	130	47,792
9.00	00900	HOUSEKEEPING	167,606	0	170,088	628	0
10.00	01000	DIETARY	205,066	0	208,102	1,988	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	145,636	0	147,792	101	0
14.00	01400	CENTRAL SERVICES & SUPPLY	108,923	0	110,536	1,675	0
16.00	01600	MEDICAL RECORDS & LIBRARY	160,265	0	162,638	218	0
17.00	01700	SOCIAL SERVICE	71,728	0	72,790	150	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	173,530	0	176,099	56	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,336,727	0	1,356,520	9,272	24,007
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	405,197	0	411,197	5,062	3,480
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,251	0	1,125,676	4,355	4,278
60.00	06000	LABORATORY	1,084,987	0	1,101,052	1,694	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	27,744	0	28,155	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	269,461	0	273,451	318	0
66.00	06600	PHYSICAL THERAPY	484,996	0	492,177	2,375	1,860
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,647	0	70,678	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,650	0	3,704	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	528,555	0	536,381	592	0
76.00	03950	SLEEP LAB	48,811	0	49,534	845	8
76.01	03951	DIABETIC EDUCATION	2,075	0	2,106	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	2,621,137	5,376	328
91.00	09100	EMERGENCY	2,226,639	0	2,259,609	2,372	13,831
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,140,495	-2,850,946	12,090,455	37,207	47,792
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	4,682	257	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	706,201	0	0
194.00	07950	RETAIL PHARMACY	0	0	322,979	0	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0
194.02	07952	KIDNEY CENTER	0	-28,618	0	1,571	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	179,769		2,850,946	825,585	42,652
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014807		0.217226	21.149866	0.892451
204.00		Cost to be allocated (per Wkst. B, Part II)	1,020		441,787	116,426	3,863
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000084		0.033662	2.982605	0.080829
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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet B-1 Date/Time Prepared: 11/16/2018 9:09 am			
Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (REQUIS.)		
	9.00	10.00	11.00	13.00	14.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.01	00570	ADMITTING				5.01	
5.02	00590	HOSPITAL ONLY A & G				5.02	
5.03	00591	SHARED ADMN & GENERAL				5.03	
6.00	00600	MAINTENANCE & REPAIRS				6.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING	38,277			9.00	
10.00	01000	DIETARY	1,988	24,467		10.00	
11.00	01100	CAFETERIA	0	19,125	8,707	11.00	
13.00	01300	NURSING ADMINISTRATION	101	0	54,833	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	0	231,331	
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	
17.00	01700	SOCIAL SERVICE	150	0	109	0	
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,272	5,342	1,625	29,824	35,527
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,062	0	249	3,913	23,036
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	708	51	31,891
60.00	06000	LABORATORY	1,694	0	974	0	1,906
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	7	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	318	0	330	27	1,691
66.00	06600	PHYSICAL THERAPY	2,375	0	488	4	6,395
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	67,449
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,570
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	131	0	5,131
76.00	03950	SLEEP LAB	845	0	37	0	3,464
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,376	0	2,163	0	16,508
91.00	09100	EMERGENCY	2,372	0	1,136	21,014	27,085
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,449	24,467	8,002	54,833	223,653
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	619	0	7,678
194.00	07950	RETAIL PHARMACY	0	0	86	0	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0
194.02	07952	KIDNEY CENTER	1,571	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	220,318	306,796	239,812	182,613	180,853
203.00		Unit cost multiplier (Wkst. B, Part I)	5.755885	12.539175	27.542437	3.330349	0.781793
204.00		Cost to be allocated (per Wkst. B, Part II)	19,053	57,708	45,108	7,178	44,711
205.00		Unit cost multiplier (Wkst. B, Part II)	0.497766	2.358605	5.180659	0.130907	0.193277
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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00590	HOSPITAL ONLY A & G			5.02
5.03	00591	SHARED ADMN & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,050,872		16.00
17.00	01700	SOCIAL SERVICE	0	2,272	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,912,113	2,272	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,579,589	0	100
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,539,912	0	0
60.00	06000	LABORATORY	5,177,336	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	58,061	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	656,552	0	0
66.00	06600	PHYSICAL THERAPY	1,483,763	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	357,512	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,993	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,601,562	0	0
76.00	03950	SLEEP LAB	315,758	0	0
76.01	03951	DIABETIC EDUCATION	3,210	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0
91.00	09100	EMERGENCY	3,352,511	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,050,872	2,272	100
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
194.00	07950	RETAIL PHARMACY	0	0	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0
194.02	07952	KIDNEY CENTER	0	0	0
200.00		Cross Foot Adjustments			
201.00		Negative Cost Centers			
202.00		Cost to be allocated (per Wkst. B, Part I)	203,833	95,639	215,858
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008843	42.094630	2,158.580000
204.00		Cost to be allocated (per Wkst. B, Part II)	10,218	6,275	7,158
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000443	2.761884	71.580000
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			

Provider CCN: 14-1304

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

Worksheet B-2
Date/Time Prepared:
11/16/2018 9:09 am

	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/RECOVERY ROOM		1 30.00	-190,478	7.00
8.00	RECOVERY ROOM		1 50.00	25,989	8.00
9.00	IV THERAPY		1 64.00	164,489	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

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

Worksheet C
Part I
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,082,997		2,082,997	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	933,537		933,537	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,593,625		1,593,625	0	0 54.00
60.00	06000 LABORATORY	1,459,906		1,459,906	0	0 60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	34,977		34,977	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	164,489		164,489	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	357,715	0	357,715	0	0 65.00
66.00	06600 PHYSICAL THERAPY	696,227	0	696,227	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	141,923		141,923	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,415		7,415	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	690,607		690,607	0	0 73.00
76.00	03950 SLEEP LAB	89,556		89,556	0	0 76.00
76.01	03951 DIABETIC EDUCATION	2,591		2,591	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	3,407,940		3,407,940	0	0 88.00
91.00	09100 EMERGENCY	2,978,711		2,978,711	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	442,456		442,456	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	15,084,672	0	15,084,672	0	0 200.00
201.00	Less Observation Beds	442,456		442,456		0 201.00
202.00	Total (see instructions)	14,642,216	0	14,642,216	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/16/2018 9:09 am		
			Title XVIII			Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00						
9.00	10.00								
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,163,035		1,163,035				30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,616	1,684,748	1,688,364	0.552924	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	143,062	6,396,850	6,539,912	0.243677	0.000000		54.00
60.00	06000	LABORATORY	329,098	4,848,238	5,177,336	0.281980	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	15,537	42,524	58,061	0.602418	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	21,030	335,257	356,287	0.461676	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	153,659	502,893	656,552	0.544839	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	285,339	1,198,424	1,483,763	0.469231	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	131,142	226,370	357,512	0.396974	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,993	12,993	0.570692	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357,820	1,243,742	1,601,562	0.431208	0.000000		73.00
76.00	03950	SLEEP LAB	0	315,758	315,758	0.283622	0.000000		76.00
76.01	03951	DIABETIC EDUCATION	0	3,210	3,210	0.807165	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	5,385,107	5,385,107				88.00
91.00	09100	EMERGENCY	30,827	3,321,684	3,352,511	0.888501	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,056	280,960	284,016	1.557856	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	2,637,221	25,798,758	28,435,979				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	2,637,221	25,798,758	28,435,979				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/16/2018 9:09 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
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
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 SLEEP LAB	0.000000		76.00
76.01	03951 DIABETIC EDUCATION	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

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

Worksheet C
Part I
Date/Time Prepared:
11/16/2018 9:09 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,082,997		2,082,997	0	2,082,997	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	933,537		933,537	0	933,537	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,593,625		1,593,625	0	1,593,625	54.00
60.00	06000 LABORATORY	1,459,906		1,459,906	0	1,459,906	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	34,977		34,977	0	34,977	63.00
64.00	06400 INTRAVENOUS THERAPY	164,489		164,489	0	164,489	64.00
65.00	06500 RESPIRATORY THERAPY	357,715	0	357,715	0	357,715	65.00
66.00	06600 PHYSICAL THERAPY	696,227	0	696,227	0	696,227	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	141,923		141,923	0	141,923	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,415		7,415	0	7,415	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	690,607		690,607	0	690,607	73.00
76.00	03950 SLEEP LAB	89,556		89,556	0	89,556	76.00
76.01	03951 DIABETIC EDUCATION	2,591		2,591	0	2,591	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	3,407,940		3,407,940	0	3,407,940	88.00
91.00	09100 EMERGENCY	2,978,711		2,978,711	0	2,978,711	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	442,456		442,456		442,456	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	15,084,672	0	15,084,672	0	15,084,672	200.00
201.00	Less Observation Beds	442,456		442,456		442,456	201.00
202.00	Total (see instructions)	14,642,216	0	14,642,216	0	14,642,216	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/16/2018 9:09 am
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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 Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,163,035		1,163,035			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,616	1,684,748	1,688,364	0.552924	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	143,062	6,396,850	6,539,912	0.243677	0.000000	54.00
60.00	06000 LABORATORY	329,098	4,848,238	5,177,336	0.281980	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	15,537	42,524	58,061	0.602418	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	21,030	335,257	356,287	0.461676	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	153,659	502,893	656,552	0.544839	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	285,339	1,198,424	1,483,763	0.469231	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	131,142	226,370	357,512	0.396974	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,993	12,993	0.570692	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	357,820	1,243,742	1,601,562	0.431208	0.000000	73.00
76.00	03950 SLEEP LAB	0	315,758	315,758	0.283622	0.000000	76.00
76.01	03951 DIABETIC EDUCATION	0	3,210	3,210	0.807165	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	5,385,107	5,385,107	0.632845	0.000000	88.00
91.00	09100 EMERGENCY	30,827	3,321,684	3,352,511	0.888501	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,056	280,960	284,016	1.557856	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	2,637,221	25,798,758	28,435,979			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	2,637,221	25,798,758	28,435,979			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/16/2018 9:09 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
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
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 SLEEP LAB	0.000000		76.00
76.01	03951 DIABETIC EDUCATION	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/16/2018 9:09 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	183,754	1,688,364	0.108836	1,326	144	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	293,138	6,539,912	0.044823	69,369	3,109	54.00
60.00	06000 LABORATORY	83,857	5,177,336	0.016197	116,154	1,881	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1,016	58,061	0.017499	6,942	121	63.00
64.00	06400 INTRAVENOUS THERAPY	0	356,287	0.000000	7,299	0	64.00
65.00	06500 RESPIRATORY THERAPY	25,867	656,552	0.039398	55,161	2,173	65.00
66.00	06600 PHYSICAL THERAPY	85,100	1,483,763	0.057354	12,257	703	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,603	357,512	0.043643	45,461	1,984	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	822	12,993	0.063265	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,723	1,601,562	0.021056	108,808	2,291	73.00
76.00	03950 SLEEP LAB	23,763	315,758	0.075257	0	0	76.00
76.01	03951 DIABETIC EDUCATION	72	3,210	0.022430	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	189,942	5,385,107	0.035272	0	0	88.00
91.00	09100 EMERGENCY	156,227	3,352,511	0.046600	9,160	427	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	64,848	284,016	0.228325	1,628	372	92.00
200.00	Total (lines 50 through 199)	1,157,732	27,272,944		433,565	13,205	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/16/2018 9:09 am
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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		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	215,858	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00 03950 SLEEP LAB	0	0	0	0	0	0	76.00
76.01 03951 DIABETIC EDUCATION	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	215,858	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/16/2018 9:09 am
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Cost Center Description	Title XVIII			Hospital	Cost		
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	215,858	0	1,688,364	0.127850	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	6,539,912	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	5,177,336	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	58,061	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	356,287	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	656,552	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	1,483,763	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	357,512	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,993	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,601,562	0.000000	73.00
76.00	03950 SLEEP LAB	0	0	0	315,758	0.000000	76.00
76.01	03951 DIABETIC EDUCATION	0	0	0	3,210	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	5,385,107	0.000000	88.00
91.00	09100 EMERGENCY	0	0	0	3,352,511	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	284,016	0.000000	92.00
200.00	Total (lines 50 through 199)	0	215,858	0	27,272,944		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/16/2018 9:09 am
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Cost Center Description		Title XVIII			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,326	170	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	69,369	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	116,154	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	6,942	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	7,299	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	55,161	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	12,257	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	45,461	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	108,808	0	0	0	73.00
76.00	03950 SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	9,160	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,628	0	0	0	92.00
200.00	Total (lines 50 through 199)		433,565	170	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:09 am
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.552924	0	400,364	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.243677	0	1,967,049	0	0
60.00 06000 LABORATORY	0.281980	0	1,538,802	0	0
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.602418	0	26,315	0	0
64.00 06400 INTRAVENOUS THERAPY	0.461676	0	151,348	630	0
65.00 06500 RESPIRATORY THERAPY	0.544839	0	176,132	0	0
66.00 06600 PHYSICAL THERAPY	0.469231	0	362,991	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396974	0	80,943	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.570692	0	26	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.431208	0	635,469	471	0
76.00 03950 SLEEP LAB	0.283622	0	96,783	0	0
76.01 03951 DIABETIC EDUCATION	0.807165	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
91.00 09100 EMERGENCY	0.888501	0	891,742	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.557856	0	130,794	0	0
200.00 Subtotal (see instructions)		0	6,458,758	1,101	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	6,458,758	1,101	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:09 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	221,371	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	479,325	0	54.00
60.00	06000 LABORATORY	433,911	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	15,853	0	63.00
64.00	06400 INTRAVENOUS THERAPY	69,874	291	64.00
65.00	06500 RESPIRATORY THERAPY	95,964	0	65.00
66.00	06600 PHYSICAL THERAPY	170,327	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32,132	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	274,019	203	73.00
76.00	03950 SLEEP LAB	27,450	0	76.00
76.01	03951 DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	792,314	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	203,758	0	92.00
200.00	Subtotal (see instructions)	2,816,313	494	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	2,816,313	494	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:09 am
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		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.552924	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243677	0	0	0	0	54.00
60.00	06000 LABORATORY	0.281980	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.602418	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.461676	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.544839	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.469231	0	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396974	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.570692	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.431208	0	0	0	0	73.00
76.00	03950 SLEEP LAB	0.283622	0	0	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.807165	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100 EMERGENCY	0.888501	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.557856	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:09 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
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
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950 SLEEP LAB	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/16/2018 9:09 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,435	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		695	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		402	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		351	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)		327	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		31	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)		31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		242	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)		234	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)		234	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,082,997	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)		4,818	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)		4,818	25.00
26.00	Total swing-bed cost (see instructions)		1,033,484	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,049,513	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,049,513	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,510.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		365,444	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)		365,444	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/16/2018 9:09 am
Cost Center Description			Title XVIII		Hospital
	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)				169,388 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				534,832 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)				353,363 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				353,363 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				706,726 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)				293 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,510.09 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				442,456 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/16/2018 9:09 am	
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	305,293	2,082,997	0.146564	442,456	64,848	90.00
91.00	Nursing School cost	0	2,082,997	0.000000	442,456	0	91.00
92.00	Allied health cost	0	2,082,997	0.000000	442,456	0	92.00
93.00	All other Medical Education	0	2,082,997	0.000000	442,456	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/16/2018 9:09 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		255,309		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.552924	1,326	733	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243677	69,369	16,904	54.00
60.00	06000 LABORATORY	0.281980	116,154	32,753	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.602418	6,942	4,182	63.00
64.00	06400 INTRAVENOUS THERAPY	0.461676	7,299	3,370	64.00
65.00	06500 RESPIRATORY THERAPY	0.544839	55,161	30,054	65.00
66.00	06600 PHYSICAL THERAPY	0.469231	12,257	5,751	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396974	45,461	18,047	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.570692	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.431208	108,808	46,919	73.00
76.00	03950 SLEEP LAB	0.283622	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.807165	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.888501	9,160	8,139	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.557856	1,628	2,536	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		433,565	169,388	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)		433,565		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1304	Period: From 07/01/2017	Worksheet D-3
	Component CCN: 14-Z304	To 06/30/2018	

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.552924	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243677	12,924	3,149	54.00
60.00	06000 LABORATORY	0.281980	63,523	17,912	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.602418	5,740	3,458	63.00
64.00	06400 INTRAVENOUS THERAPY	0.461676	6,140	2,835	64.00
65.00	06500 RESPIRATORY THERAPY	0.544839	35,752	19,479	65.00
66.00	06600 PHYSICAL THERAPY	0.469231	162,093	76,059	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396974	39,773	15,789	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.570692	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.431208	81,999	35,359	73.00
76.00	03950 SLEEP LAB	0.283622	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.807165	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.888501	89	79	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.557856	1,428	2,225	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		409,461	176,344	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)		409,461		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/16/2018 9:09 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,816,807 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)			2,816,807 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			2,844,975 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			21,324 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			974,469 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)			1,849,182 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)			1,849,182 30.00
31.00	Primary payer payments			887 31.00
32.00	Subtotal (line 30 minus line 31)			1,848,295 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			136,164 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			88,507 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			124,012 36.00
37.00	Subtotal (see instructions)			1,936,802 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)			1,936,802 40.00
40.01	Sequestration adjustment (see instructions)			38,736 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			1,878,202 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			19,864 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1304		Period: From 07/01/2017 To 06/30/2018		Worksheet E-1 Part I Date/Time Prepared: 11/16/2018 9:09 am	
		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		419,433		1,906,517	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	01/11/2018	36,745		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	01/11/2018	28,315	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)		36,745		-28,315	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)		456,178		1,878,202	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		1,181		19,864	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		457,359		1,898,066	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: 14-1304
Component CCN: 14-Z304

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

Worksheet E-1
Part I
Date/Time Prepared:
11/16/2018 9:09 am

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		829,166		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	01/11/2018	30,537		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		30,537		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)		859,703		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		10,290		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		869,993		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: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/16/2018 9:09 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/16/2018 9:09 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	713,793	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)	178,107	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	468	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)	891,900	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	891,900	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)	891,900	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,152	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)	887,748	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)	887,748	0	19.00
19.01	Sequestration adjustment (see instructions)	17,755	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	859,703	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)	10,290	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1304	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/16/2018 9:09 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			534,832 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)			534,832 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			540,180 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			540,180 19.00
20.00	Deductibles (exclude professional component)			80,924 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			459,256 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			459,256 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			11,442 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			7,437 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,038 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			466,693 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)			466,693 30.00
30.01	Sequestration adjustment (see instructions)			9,334 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			456,178 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			1,181 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: 14-1304

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

Worksheet G

Date/Time Prepared:
11/16/2018 9:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	413,244	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,533,720	0	0	0	4.00
5.00	Other receivable	18,514	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,979,298	0	0	0	6.00
7.00	Inventory	132,601	0	0	0	7.00
8.00	Prepaid expenses	119,723	0	0	0	8.00
9.00	Other current assets	787,441	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)	4,025,945	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	326,868	0	0	0	13.00
14.00	Accumulated depreciation	-83,607	0	0	0	14.00
15.00	Buildings	12,646,848	0	0	0	15.00
16.00	Accumulated depreciation	-2,622,469	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	2,301,741	0	0	0	19.00
20.00	Accumulated depreciation	-1,006,808	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	109,793	0	0	0	23.00
24.00	Accumulated depreciation	-120,772	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,616,594	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,390,429	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	1,066,483	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,456,912	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,099,451	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	241,737	0	0	0	37.00
38.00	Salaries, wages, and fees payable	378,496	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,979,787	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	398,889	0	0	0	43.00
44.00	Other current liabilities	173,410	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,172,319	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,092,321	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)	6,092,321	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,264,640	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,834,811				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)	4,834,811	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,099,451	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1304

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

Worksheet G-1

Date/Time Prepared:
11/16/2018 9:09 am

		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		4,905,245		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		303,566			2.00
3.00	Total (sum of line 1 and line 2)		5,208,811		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		5,208,811		0	11.00
12.00	OTHER	374,000		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		374,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,834,811		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	OTHER		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: 14-1304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/16/2018 9:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	553,637		553,637	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	560,009		560,009	5.00
6.00	Swing bed - NF	49,389		49,389	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,163,035		1,163,035	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,163,035		1,163,035	17.00
18.00	Ancillary services	1,440,303	17,100,053	18,540,356	18.00
19.00	Outpatient services	33,883	3,641,884	3,675,767	19.00
20.00	RURAL HEALTH CLINIC	0	5,385,107	5,385,107	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL CHARGES	17,041	1,856,643	1,873,684	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	1,369,208	1,369,208	27.01
27.02	RETAIL PHARMACY	0	96,457	96,457	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,654,262	29,449,352	32,103,614	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,704,759		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,704,759		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1304

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

Worksheet G-3

Date/Time Prepared:
11/16/2018 9:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,103,614	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,457,417	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,646,197	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,704,759	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,058,562	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	10,076	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	69	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	58,271	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	19,795	22.00
23.00	Governmental appropriations	17,890	23.00
24.00	INTERCOMPANY REVENUE	1,059,838	24.00
24.01	MISC INCOME	196,189	24.01
25.00	Total other income (sum of lines 6-24)	1,362,128	25.00
26.00	Total (line 5 plus line 25)	303,566	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)	303,566	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1304 Component CCN: 14-3453		Period: From 07/01/2017 To 06/30/2018		Worksheet M-1 Date/Time Prepared: 11/16/2018 9:09 am	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	972,619	68,547	1,041,166	0	1,041,166	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	416,342	29,343	445,685	0	445,685	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	262,016	18,466	280,482	0	280,482	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	64,421	4,540	68,961	0	68,961	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	199,539	14,063	213,602	0	213,602	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,914,937	134,959	2,049,896	0	2,049,896	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	8,750	8,750	0	8,750	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8,750	8,750	0	8,750	14.00
15.00	Medical Supplies	0	16,508	16,508	14,886	31,394	15.00
16.00	Transportation (Health Care Staff)	0	3,181	3,181	0	3,181	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	10,960	10,960	0	10,960	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,649	30,649	14,886	45,535	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,914,937	174,358	2,089,295	14,886	2,104,181	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	28,625	28,625	-14,886	13,739	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	28,625	28,625	-14,886	13,739	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	89,648	89,648	-11,745	77,903	29.00
30.00	Administrative Costs	335,913	158,076	493,989	-227,334	266,655	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	335,913	247,724	583,637	-239,079	344,558	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,250,850	450,707	2,701,557	-239,079	2,462,478	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-3453

To 06/30/2018

Date/Time Prepared: 11/16/2018 9:09 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,041,166		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	445,685		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	280,482		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	68,961		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	213,602		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,049,896		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	8,750		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8,750		14.00
15.00	Medical Supplies	0	31,394		15.00
16.00	Transportation (Health Care Staff)	0	3,181		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	10,960		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	45,535		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,104,181		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	13,739		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,739		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	77,903		29.00
30.00	Administrative Costs	-4,131	262,524		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,131	340,427		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,131	2,458,347		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2017 To 06/30/2018	Worksheet M-2 Date/Time Prepared: 11/16/2018 9:09 am
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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	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	3.27	13,600	4,200	13,734	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.97	8,633	2,100	6,237	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.24	22,233		19,971	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	0.94	1,778		1,778	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)	7.18	24,011		24,011	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,104,181	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				13,739	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,117,920	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.993513	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				340,427	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				949,593	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,290,020	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,290,020	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,281,652	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,385,833	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/16/2018 9:09 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,385,833	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			31,051	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,354,782	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,011	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)			24,011	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			139.72	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)	139.72	139.72		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,888		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	682,951		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	45		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	6,287		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	6,287		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	689,238		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,080,654		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,736		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,485		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.)		483,398		16.04
16.05	Total program cost (see instructions)	0	490,883		16.05
17.00	Primary payer amounts		551		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		77,505		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		198,283		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		490,332		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,133		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		496,465		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		496,465		26.00
26.01	Sequestration adjustment (see instructions)		9,929		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		426,487		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)		60,049		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: 14-1304 Component CCN: 14-3453	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/16/2018 9:09 am
		Title XVIII	RHC I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,049,896	2,049,896	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002152	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	4,411	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	14,886	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	19,297	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,104,181	2,104,181	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,281,652	1,281,652	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.009171	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	11,754	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	31,051	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	481	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	64.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	95	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	6,133	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)		31,051	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)		6,133	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/16/2018 9:09 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		418,196	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		01/11/2018	8,291	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		8,291	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		426,487	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		60,049	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		486,536	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00