

State Copy

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: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/26/2018 10:17 am
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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: 9/26/2018 Time: 10:17 am
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 PINCKNEYVILLE COMMUNITY HOSPITAL (14-1307) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 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.

Encrypt on Information

ECR: Date: 9/26/2018 Time: 10:17 am
v27oqdnDgxx.5aewcUykAmuXgGpqr0
p.: k003zDvEnL3UYI wHOHwGS6W5gbm
kYaY0Xu9YL0eh6RZ

PI: Date: 9/26/2018 Time: 10:17 am
o3QXxqPf6ES1esWuQZ7TU7G1ZWf5r0
4CBDq0ml 9A04Xmg1whtlFYGDGsqZhw
X9C50qZUoa0l qaUH

(Signed) _____

Officer or Administrator of Provider(s)

Title _____

Date _____

	Title V	Title XVIII		Title IX	Title XIX
		Part A	Part B		
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	-152,476	-179,777	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	-150,738	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	22,174	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
200.00 Total	0	-303,214	-157,603	0	0

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.



Accountant's Compilation Report

Board of Directors
Pinckneyville Community Hospital District
Pinckneyville, IL 62274

Management is responsible for the accompanying Medicare Cost Report of Pinckneyville Community Hospital District, included in the accompanying prescribed form as of and for the year ended April 30, 2018. We have performed a compilation engagement in accordance with *Statements on Standards for Accounting and Review Services* promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the Medicare Cost Report included in the accompanying prescribed form nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on this Medicare Cost Report.

Other Matter

The Medicare Cost Report included in the accompanying prescribed form is intended to comply with the requirements of the Centers for Medicare and Medicaid Services and is not intended to be a presentation in accordance with accounting principles generally accepted in the United States.

Restriction on Use

Our report and the prescribed form are intended solely for the information and use of Pinckneyville Community Hospital District and the Centers for Medicare and Medicaid Services and is not intended to be, and should not be, used by anyone other than these specified parties.

A handwritten signature in cursive script that reads "Wipfli LLP".

Wipfli LLP

September 26, 2018
Eau Claire, Wisconsin

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 5383 STATE ROUTE 154	PO Box:	3.00 State: IL	4.00 Zip Code: 62274-1034	County: PERRY	1.00
2.00 City: PINCKNEYVILLE						2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PINCKNEYVILLE COMMUNITY HOSPITAL	141307	99914	1	11/30/2000	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	PINCKNEYVILLE CRITICAL ACC SWING BED	14Z307	99914		02/06/2001	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	PINCKNEYVILLE HOSPITAL RHC	143412	99914		03/27/1995	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)					05/01/2017		04/30/2018		20.00
21.00	Type of Control (see instructions)					11				21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
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.							24.00
	0	0	0	0	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307			Period: From 05/01/2017 To 04/30/2018		Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural	S Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					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	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet S-2
Part I
Date/Time Prepared:
9/26/2018 10:11 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am	
	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
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am	
			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	N			109.00
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					1.00			
					2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N			111.00
					1.00			
					2.00			
					3.00			
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1			118.00
					1.00			
					2.00			
					3.00			
118.01	List amounts of malpractice premiums and paid losses:	Premiums		Losses		Insurance		
		1.00		2.00		3.00		
		45,972		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
DO NOT USE THIS LINE								
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		119.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 10:11 am
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet S-2 Part II Date/Time Prepared: 9/26/2018 10:11 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)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			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	07/09/2018	Y	07/09/2018
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: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 9/26/2018 10:11 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL		TRACZEK	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6619		PTRACZEK@WI PFLI . COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 9/26/2018 10:11 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.	PARTNER		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

HFS Supplemental Information		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part IX Date/Time Prepared: 9/26/2018 10:11 am	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	17	6,205	33,312.00	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)		17	6,205	33,312.00	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)		17	6,205	33,312.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
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)		17				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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2018 10:11 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)	1,053	110	1,389			1.00
2.00 HMO and other (see instructions)	49	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,220	0	1,359			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	293			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,273	110	3,041			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	2,273	110	3,041	0.00	164.18	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	6,602	3,597	18,427	0.00	30.92	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	195.10	27.00
28.00 Observation Bed Days		28	255			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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2018 10:11 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	266	30	363	1.00
2.00 HMO and other (see instructions)				13	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	266	30	363	14.00	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	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
25.10 CMHC - CORF	0.00						25.10
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: 14-1307 Component CCN: 14-3412		Period: From 05/01/2017 To 04/30/2018		Worksheet S-8 Date/Time Prepared: 9/26/2018 10:11 am	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	5383 STATE ROUTE 154				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	PINCKNEYVILLE		IL		62274	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00		Source of Federal Funds				4.00	
5.00		Community Health Center (Section 330(d), PHS Act)				5.00	
6.00		Migrant Health Center (Section 329(d), PHS Act)				6.00	
7.00		Health Services for the Homeless (Section 340(d), PHS Act)				7.00	
8.00		Appalachian Regional Commission				8.00	
9.00		Look-Alikes				8.00	
9.00		OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) CLINIC	08:30		19:00		08:30	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County		4.00			
2.00	City, State, ZIP Code, County	PERRY				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) CLINIC	19:00		08:30		19:00	
		08:30		19:00		08:30	
		19:00		08:30		19:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1307 Component CCN: 14-3412		Period: From 05/01/2017 To 04/30/2018		Worksheet S-8 Date/Time Prepared: 9/26/2018 10:11 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	08:30	17:00	09:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet S-10 Date/Time Prepared: 9/26/2018 10:11 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)		0.532516	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,282,519	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		174,517	5.00	
6.00	Medicaid charges		5,015,131	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,670,637	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)		1,213,601	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		282,276	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,213,601	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)	322,896	211,843	534,739	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	171,947	211,843	383,790	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)	171,947	211,843	383,790	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)		554,588	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		276,790	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		425,831	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		128,757	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		217,606	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		601,396	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,814,997	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		1,712,314	1,712,314	803,941	2,516,255	1.00
1.01	00101		0	0	0	0	1.01
1.02	00102		0	0	722	722	1.02
1.03	00103		0	0	14,829	14,829	1.03
1.04	00104		0	0	622	622	1.04
2.00	00200		601,054	601,054	0	601,054	2.00
2.01	00201		0	0	0	0	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400	81,967	3,151,418	3,233,385	5,894	3,239,279	4.00
5.00	00500	1,434,903	1,192,945	2,627,848	-34,470	2,593,378	5.00
6.00	00600	286,729	569,416	856,145	-9,133	847,012	6.00
8.00	00800	30,310	93,944	124,254	0	124,254	8.00
9.00	00900	330,867	36,963	367,830	0	367,830	9.00
10.00	01000	307,796	154,647	462,443	0	462,443	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	390,708	15,190	405,898	0	405,898	13.00
14.00	01400	24,184	4,621	28,805	0	28,805	14.00
15.00	01500	305,339	1,669,612	1,974,951	0	1,974,951	15.00
16.00	01600	307,799	23,394	331,193	0	331,193	16.00
17.00	01700	40,570	3,860	44,430	0	44,430	17.00
19.00	01900	0	297,811	297,811	0	297,811	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,537,881	167,126	1,705,007	133,116	1,838,123	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	128,593	240,304	368,897	-54,867	314,030	50.00
53.00	05300	0	7,908	7,908	0	7,908	53.00
54.00	05400	475,637	150,723	626,360	1,904	628,264	54.00
54.01	05401	206,713	299,666	506,379	-1,450	504,929	54.01
56.00	05600	71,333	86,899	158,232	0	158,232	56.00
57.00	05700	55,534	92,865	148,399	0	148,399	57.00
58.00	05800	0	177,310	177,310	0	177,310	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	533,750	575,757	1,109,507	7,493	1,117,000	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	235,851	60,558	296,409	-3,780	292,629	65.00
66.00	06600	348,834	28,503	377,337	0	377,337	66.00
67.00	06700	129,001	3,535	132,536	0	132,536	67.00
68.00	06800	77,136	2,956	80,092	0	80,092	68.00
69.00	06900	3,075	19,292	22,367	0	22,367	69.00
70.00	07000	377	1,603	1,980	0	1,980	70.00
71.00	07100	0	0	0	71,434	71,434	71.00
72.00	07200	0	0	0	27,884	27,884	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	193,259	105,386	298,645	0	298,645	76.00
76.01	03020	0	0	0	0	0	76.01
76.02	03030	0	55,879	55,879	0	55,879	76.02
76.97	07697	34,152	2,312	36,464	0	36,464	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,916,078	213,960	2,130,038	-152,216	1,977,822	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	13,607	69,230	82,837	0	82,837	90.00
90.01	09002	16,575	1,133	17,708	0	17,708	90.01
90.02	04050	765	1,395	2,160	0	2,160	90.02
91.00	09100	469,341	1,631,020	2,100,361	-20,845	2,079,516	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300		794,317	794,317	-794,317	0	113.00
118.00		9,988,664	14,316,826	24,305,490	-3,239	24,302,251	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	596	596	0	596	192.00
192.01	19201	61,753	2,247	64,000	-5,894	58,106	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet A Date/Time Prepared: 9/26/2018 10:11 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		
192.04	19204	VACANT SPACE	0	4,771	4,771	9,133	13,904	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		TOTAL (SUM OF LINES 118 through 199)	10,050,417	14,324,440	24,374,857	0	24,374,857	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A
Date/Time Prepared:
9/26/2018 10:11 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	-155,285	2,360,970	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	722	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	14,829	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	622	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-154,405	446,649	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6	3,239,273	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-130,308	2,463,070	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	847,012	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,254	8.00
9.00	00900	HOUSEKEEPING	0	367,830	9.00
10.00	01000	DIETARY	-59,707	402,736	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-34	405,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-959	27,846	14.00
15.00	01500	PHARMACY	-14,231	1,960,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,791	327,402	16.00
17.00	01700	SOCIAL SERVICE	0	44,430	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	297,811	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-177,430	1,660,693	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-10	314,020	50.00
53.00	05300	ANESTHESIOLOGY	0	7,908	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,683	623,581	54.00
54.01	05401	ONCOLOGY	-276,000	228,929	54.01
56.00	05600	RADIOISOTOPE	0	158,232	56.00
57.00	05700	CT SCAN	0	148,399	57.00
58.00	05800	MRI	0	177,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-7,144	1,109,856	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-2,748	289,881	65.00
66.00	06600	PHYSICAL THERAPY	-3,177	374,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	-3,620	128,916	67.00
68.00	06800	SPEECH PATHOLOGY	-14,038	66,054	68.00
69.00	06900	ELECTROCARDIOLOGY	-11,613	10,754	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,980	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	298,645	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	76.01
76.02	03030	SLEEP STUDY	-2,880	52,999	76.02
76.97	07697	CARDIAC REHABILITATION	0	36,464	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-792	1,977,030	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	82,837	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	17,708	90.01
90.02	04050	TELEMEDICINE	0	2,160	90.02
91.00	09100	EMERGENCY	-735,226	1,344,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,758,087	22,544,164	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	596	192.00
192.01	19201	FITNESS CENTER	0	58,106	192.01
192.02	19202	RETAIL PHARMACY	0	0	192.02
192.03	19203	LEASED SPACE	0	0	192.03
192.04	19204	VACANT SPACE	0	13,904	192.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.05	19205	MEALS ON WHEELS	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	192.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,758,087	22,616,770	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet Non-CMS W Date/Time Prepared: 9/26/2018 10:11 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-NEW BLDG	00101		1.01
1.02	NEW CAP REL COSTS-PT BLDG	00102		1.02
1.03	NEW CAP REL COSTS-RHC BLDG	00103		1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	00104		1.04
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	00201		2.01
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ONCOLOGY	05401		54.01
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	SENIOR LIFE SOLUTIONS	03950		76.00
76.01	OP IV THERAPY/NURSING	03020	ACUPUNCTURE	76.01
76.02	SLEEP STUDY	03030	ANGIOCARDIOGRAPHY	76.02
76.97	CARDIAC REHABILITATION	07697		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	COUMADIN, CHF/COPD CLINIC	09002		90.01
90.02	TELEMEDICINE	04050	TELEMEDICINE	90.02
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	FITNESS CENTER	19201		192.01
192.02	RETAIL PHARMACY	19202		192.02
192.03	LEASED SPACE	19203		192.03

COST CENTERS USED IN COST REPORT		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet Non-CMS W Date/Time Prepared: 9/26/2018 10:11 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
192.04	VACANT SPACE	19204		192.04
192.05	MEALS ON WHEELS	19205		192.05
192.06	15 N MAIN BUILDING	19206		192.06
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	785,644	1.00
2.00	LABORATORY	60.00	0	1,773	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,900	3.00
	TOTALS		0	794,317	
C - RHC PHYSICIAN					
1.00	ADULTS & PEDIATRICS	30.00	142,694	3,802	1.00
	TOTALS		142,694	3,802	
D - DEPRECIATION					
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	52	1.00
2.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	14,829	2.00
	TOTALS		0	14,881	
E - RHC LAB					
1.00	LABORATORY	60.00	2,503	3,217	1.00
	TOTALS		2,503	3,217	
F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,178	1.00
2.00	NEW CAP REL COSTS-PT BLDG	1.02	0	670	2.00
3.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	622	3.00
	TOTALS		0	34,470	
G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	27,884	1.00
	TOTALS		0	27,884	
H - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	71,434	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	71,434	
I - FITNESS CENTER RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,894	1.00
	TOTALS		0	5,894	
J - VACANT SPACE RECLASS					
1.00	VACANT SPACE	192.04	0	9,133	1.00
	TOTALS		0	9,133	
500.00	Grand Total: Increases		145,197	965,032	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	794,317	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	794,317			
C - RHC PHYSICIAN							
1.00	RURAL HEALTH CLINIC	88.00	142,694	3,802	0		1.00
	TOTALS		142,694	3,802			
D - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,881	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	14,881			
E - RHC LAB							
1.00	RURAL HEALTH CLINIC	88.00	2,503	3,217	0		1.00
	TOTALS		2,503	3,217			
F - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,470	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	34,470			
G - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	27,884	0		1.00
	TOTALS		0	27,884			
H - MEDICAL SUPPLIES RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	13,380	0		1.00
2.00	OPERATING ROOM	50.00	0	26,983	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,996	0		3.00
4.00	ONCOLOGY	54.01	0	1,450	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	3,780	0		5.00
6.00	EMERGENCY	91.00	0	20,845	0		6.00
	TOTALS		0	71,434			
I - FITNESS CENTER RECLASS							
1.00	FITNESS CENTER	192.01	0	5,894	0		1.00
	TOTALS		0	5,894			
J - VACANT SPACE RECLASS							
1.00	MAINTENANCE & REPAIRS	6.00	0	9,133	0		1.00
	TOTALS		0	9,133			
500.00	Grand Total: Decreases		145,197	965,032			500.00

		Increases			Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - INTEREST									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	785,644	INTEREST EXPENSE	113.00	0	794,317	1.00
2.00	LABORATORY	60.00	0	1,773		0.00	0	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,900		0.00	0	0	3.00
	TOTALS		0	794,317	TOTALS		0	794,317	
C - RHC PHYSICIAN									
1.00	ADULTS & PEDIATRICS	30.00	142,694	3,802	RURAL HEALTH CLINIC	88.00	142,694	3,802	1.00
	TOTALS		142,694	3,802	TOTALS		142,694	3,802	
D - DEPRECIATION									
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	52	CAP REL COSTS-BLDG & FIXT	1.00	0	14,881	1.00
2.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	14,829		0.00	0	0	2.00
	TOTALS		0	14,881	TOTALS		0	14,881	
E - RHC LAB									
1.00	LABORATORY	60.00	2,503	3,217	RURAL HEALTH CLINIC	88.00	2,503	3,217	1.00
	TOTALS		2,503	3,217	TOTALS		2,503	3,217	
F - PROPERTY INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,178	ADMINISTRATIVE & GENERAL	5.00	0	34,470	1.00
2.00	NEW CAP REL COSTS-PT BLDG	1.02	0	670		0.00	0	0	2.00
3.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	622		0.00	0	0	3.00
	TOTALS		0	34,470	TOTALS		0	34,470	
G - IMPLANTABLE DEVICES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	27,884	OPERATING ROOM	50.00	0	27,884	1.00
	TOTALS		0	27,884	TOTALS		0	27,884	
H - MEDICAL SUPPLIES RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	71,434	ADULTS & PEDIATRICS	30.00	0	13,380	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	26,983	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	4,996	3.00
4.00		0.00	0	0	ONCOLOGY	54.01	0	1,450	4.00
5.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	3,780	5.00
6.00		0.00	0	0	EMERGENCY	91.00	0	20,845	6.00
	TOTALS		0	71,434	TOTALS		0	71,434	
I - FITNESS CENTER RECLASS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,894	FITNESS CENTER	192.01	0	5,894	1.00
	TOTALS		0	5,894	TOTALS		0	5,894	
J - VACANT SPACE RECLASS									
1.00	VACANT SPACE	192.04	0	9,133	MAINTENANCE & REPAIRS	6.00	0	9,133	1.00
	TOTALS		0	9,133	TOTALS		0	9,133	
500.00	Grand Total: Increases		145,197	965,032	Grand Total: Decreases		145,197	965,032	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-7
Part I
Date/Time Prepared:
9/26/2018 10:11 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	658,227	0	0	0	0	1.00
2.00	Land Improvements	2,819,384	69,800	0	69,800	0	2.00
3.00	Buildings and Fixtures	29,231,619	381,185	0	381,185	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,274,588	661,854	0	661,854	177,535	6.00
7.00	HIT designated Assets	1,682,322	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,666,140	1,112,839	0	1,112,839	177,535	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,666,140	1,112,839	0	1,112,839	177,535	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	658,227	0				1.00
2.00	Land Improvements	2,889,184	0				2.00
3.00	Buildings and Fixtures	29,612,804	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,758,907	0				6.00
7.00	HIT designated Assets	1,682,322	0				7.00
8.00	Subtotal (sum of lines 1-7)	40,601,444	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40,601,444	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-7
Part II
Date/Time Prepared:
9/26/2018 10:11 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	1,712,314	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	601,054	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,313,368	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	1,712,314	1.00			
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	1.01			
1.02	NEW CAP REL COSTS-PT BLDG	0	0	1.02			
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	1.03			
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	1.04			
2.00	CAP REL COSTS-MVBLE EQUIP	0	601,054	2.00			
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	2.01			
3.00	Total (sum of lines 1-2)	0	2,313,368	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-7
Part III
Date/Time Prepared:
9/26/2018 10:11 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	29,612,804	0	29,612,804	0.799179	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0.000000	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	7,441,229	0	7,441,229	0.200821	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	37,054,033	0	37,054,033	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,697,433	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	52	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	14,829	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	446,649	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,158,963	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 col. 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	630,359	33,178	0	0	2,360,970	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	670	0	0	722	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0	14,829	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	622	0	0	622	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	446,649	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	630,359	34,470	0	0	2,823,792	3.00

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-155,285	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-NEW BLDG (chapter 2)			NEW CAP REL COSTS-NEW BLDG	1.01		1.01
1.02 Investment income - NEW CAP REL COSTS-PT BLDG (chapter 2)			NEW CAP REL COSTS-PT BLDG	1.02		1.02
1.03 Investment income - NEW CAP REL COSTS-RHC BLDG (chapter 2)			NEW CAP REL COSTS-RHC BLDG	1.03		1.03
1.04 Investment income - CAP REL COSTS-15 N MAIN BLDG (chapter 2)			CAP REL COSTS-15 N MAIN BLDG	1.04		1.04
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00		2.00
2.01 Investment income - CAP REL COSTS-MVBLE EQUIP NEW BLDG (chapter 2)			CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01		2.01
3.00 Investment income - other (chapter 2)		0		0.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-8,549	PHARMACY	15.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		7.00
8.00 Television and radio service (chapter 21)	A	-3,540	ADMINISTRATIVE & GENERAL	5.00		8.00
9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-1,206,029				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00 Laundry and linen service		0		0.00		13.00
14.00 Cafeteria-employees and guests	B	-58,012	DIETARY	10.00		14.00
15.00 Rental of quarters to employees and others		0		0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		16.00
17.00 Sale of drugs to other than patients		0		0.00		17.00
18.00 Sale of medical records and abstracts	B	-3,791	MEDICAL RECORDS & LIBRARY	16.00		18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		19.00
20.00 Vending machines	B	-75	ADMINISTRATIVE & GENERAL	5.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		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

Line #	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.
				3.00	4.00	5.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.01	Depreciation - NEW CAP REL COSTS-NEW BLDG			ONEW CAP REL COSTS-NEW BLDG	1.01	0 26.01
26.02	Depreciation - NEW CAP REL COSTS-PT BLDG			ONEW CAP REL COSTS-PT BLDG	1.02	0 26.02
26.03	Depreciation - NEW CAP REL COSTS-RHC BLDG			ONEW CAP REL COSTS-RHC BLDG	1.03	0 26.03
26.04	Depreciation - CAP REL COSTS-15 N MAIN BLDG			OCAP REL COSTS-15 N MAIN BLDG	1.04	0 26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP NEW BLDG			OCAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0 27.01
28.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00	0 28.00
29.00	Physicians' assistant			O	0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00	0 30.00
30.99	Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00	0 30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00	0 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-154,405	CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00	NONPATIENT CARE RELATED PROPERTY INS	A	-5,695	ADMINISTRATIVE & GENERAL	5.00	0 33.00
34.00	MISCELLANEOUS INCOME	B	-2,566	ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0	O	0.00	0 34.01
34.02	REBATE - CENTRAL SUPPLY	B	-959	CENTRAL SERVICES & SUPPLY	14.00	0 34.02
34.03	REBATE - DIETARY	B	-523	DIETARY	10.00	0 34.03
34.04	REBATE - COMMUNICATIONS	B	-182	ADMINISTRATIVE & GENERAL	5.00	0 34.04
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0	O	0.00	0 35.00
36.00	MOBILE PET SCAN RENTAL	B	-4,675	RADIOLOGY-DIAGNOSTIC	54.00	0 36.00
37.00	NON-ALLOWABLE LOBBYING	A	-10,507	ADMINISTRATIVE & GENERAL	5.00	0 37.00
37.01	NON-ALLOWABLE LOBBYING	A	-2	DIETARY	10.00	0 37.01
37.02	NON-ALLOWABLE LOBBYING	A	-34	NURSING ADMINISTRATION	13.00	0 37.02
37.03	NON-ALLOWABLE LOBBYING	A	-10	OPERATING ROOM	50.00	0 37.03
37.04	NON-ALLOWABLE LOBBYING	A	-8	RADIOLOGY-DIAGNOSTIC	54.00	0 37.04
37.05	NON-ALLOWABLE LOBBYING	A	-792	RURAL HEALTH CLINIC	88.00	0 37.05
37.06	NON-ALLOWABLE LOBBYING	A	-6	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 37.06
37.07	NON-ALLOWABLE LOBBYING	A	-18	RESPIRATORY THERAPY	65.00	0 37.07
38.00	NON-ALLOWABLE LOBBYING	A	-61	PHYSICAL THERAPY	66.00	0 38.00
39.00	NON-ALLOWABLE ADVERTISING	A	-85,138	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00	GIFTS & DONATIONS	A	-1,020	ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00	OTHER ENTERTAINMENT	A	-550	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00	COMMUNITY EDUCATION	A	-16,014	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00	OUTSIDE SERVICES - PHYSICAL THERAPY	B	-3,116	PHYSICAL THERAPY	66.00	0 43.00
43.01	OUTSIDE SERVICES - OCCUP THERAPY	B	-3,620	OCCUPATIONAL THERAPY	67.00	0 43.01
43.02	OUTSIDE SERVICES - SPEECH PATHOLOGY	B	-14,038	SPEECH PATHOLOGY	68.00	0 43.02
43.04	OUTSIDE SERVICES - LAB	B	-7,144	LABORATORY	60.00	0 43.04
44.00	LIABILITY CLAIMS	A	-5,021	ADMINISTRATIVE & GENERAL	5.00	0 44.00
45.00	SPECIALTY CLINIC SUPPORT	A	150	RESPIRATORY THERAPY	65.00	0 45.00
46.00	DIETICIAN'S CONSULTS	B	-1,170	DIETARY	10.00	0 46.00
47.00	NON-HOSP RX	B	-5,682	PHARMACY	15.00	0 47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,758,087			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.

Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet A-8 Date/Time Prepared: 9/26/2018 10:11 am
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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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-8-2

Date/Time Prepared:
9/26/2018 10:11 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	30.00	DR. F	69,313	69,313	0	0	0	1.00
2.00	30.00	DR. R	48,932	48,932	0	0	0	2.00
3.00	30.00	DR. F	28,251	28,251	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,531,721	735,226	796,495	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	30,934	30,934	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	276,000	276,000	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	21,385	0	21,385	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	2,880	2,880	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	2,880	2,880	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	11,613	11,613	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	30,000	0	30,000	0	0	11.00
200.00			2,053,909	1,206,029	847,880		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. F	0	0	0	0	0	1.00
2.00	30.00	DR. R	0	0	0	0	0	2.00
3.00	30.00	DR. F	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. F	0	0	0	69,313		1.00
2.00	30.00	DR. R	0	0	0	48,932		2.00
3.00	30.00	DR. F	0	0	0	28,251		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	735,226		4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	30,934		5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	276,000		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	2,880		8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	2,880		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	11,613		10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0		11.00
200.00			0	0	0	1,206,029		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/26/2018 10:11 am	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					36	1.00
2.00	Line 1 multiplied by 15 hours per week					540	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					36	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					5.38	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	377.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.01	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)	41.51	41.51	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)					31,316	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)					31,316	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)					31,316	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)					83.01	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					44,825	22.00
23.00	Total salary equivalency (see instructions)					44,825	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,494	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,494	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)					194	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,688	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)					1,688	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					194	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/26/2018 10:11 am		
						Physical Therapy	Cost	
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
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)	83.01	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)						44,825	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,688	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)						46,513	63.00
64.00	Total cost of outside supplier services (from your records)						22,645	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,494	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						194	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,688	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						194	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						194	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/26/2018 10:11 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					8	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					5.38	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	16.57	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.69	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)	39.35	39.35	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)					1,304	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)					1,304	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)					1,304	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)					1,304	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)					315	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)					315	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)					43	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					358	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)					358	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					43	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: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/26/2018 10:11 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)	78.69	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)					1,304	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					358	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)					1,662	63.00
64.00	Total cost of outside supplier services (from your records)					994	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					315	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					43	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					358	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					43	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					43	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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,360,970	2,360,970				1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	722	0	0	722		1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	14,829	0	0	0	14,829	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	622	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	446,649					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,239,273	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,463,070	545,470	0	11	2,451	5.00
6.00	00600	MAINTENANCE & REPAIRS	847,012	170,961	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,254	11,168	0	0	0	8.00
9.00	00900	HOUSEKEEPING	367,830	22,337	0	0	0	9.00
10.00	01000	DIETARY	402,736	105,078	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	405,864	10,959	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,846	35,917	0	0	0	14.00
15.00	01500	PHARMACY	1,960,720	35,393	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327,402	35,629	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	44,430	2,491	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	297,811	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,660,693	248,013	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	314,020	243,162	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	7,908	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,581	145,373	0	0	0	54.00
54.01	05401	ONCOLOGY	228,929	72,359	0	0	0	54.01
56.00	05600	RADIOLOGY-SOTOPE	158,232	7,760	0	0	0	56.00
57.00	05700	CT SCAN	148,399	23,884	0	0	0	57.00
58.00	05800	MRI	177,310	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,109,856	70,996	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	289,881	80,145	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	374,160	0	0	493	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,916	0	0	79	0	67.00
68.00	06800	SPEECH PATHOLOGY	66,054	0	0	10	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,754	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,980	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71,434	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,884	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	298,645	24,146	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	52,999	12,191	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	36,464	5,820	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,977,030	265,421	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	82,837	3,408	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	17,708	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	2,160	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,344,290	154,234	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,544,164	2,332,315	0	593	2,451	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,985	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	596	17,670	0	0	0	192.00
192.01	19201	FITNESS CENTER	58,106	0	0	4	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	1.03	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	13,904	0	0	125	12,378	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	22,616,770	2,360,970	0	722	14,829	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
		1.04	2.00	2.01			
GENERAL SERVICE COST CENTERS					4.00	4A	
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	622				1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		446,649			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG		0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	3,239,273	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	108,277	0	466,709	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	29,194	0	93,260	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,907	0	9,858	8.00
9.00	00900	HOUSEKEEPING	0	3,814	0	107,616	9.00
10.00	01000	DIETARY	0	17,944	0	100,112	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,871	0	127,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,133	0	7,866	14.00
15.00	01500	PHARMACY	0	6,044	0	99,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,084	0	100,113	16.00
17.00	01700	SOCIAL SERVICE	0	425	0	13,196	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	297,811	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	42,352	0	547,852	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	41,524	0	41,826	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,825	0	154,703	54.00
54.01	05401	ONCOLOGY	0	12,356	0	67,234	54.01
56.00	05600	RADIO SOTOP	0	1,325	0	23,201	56.00
57.00	05700	CT SCAN	0	4,079	0	18,063	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,124	0	174,419	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,686	0	76,712	65.00
66.00	06600	PHYSICAL THERAPY	0	23,898	0	113,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,814	0	41,958	67.00
68.00	06800	SPEECH PATHOLOGY	0	479	0	25,089	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	123	70.00
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	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	209	9,173	0	62,858	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	2,082	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	994	0	11,108	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	45,325	0	574,749	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	582	0	4,426	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	5,391	90.01
90.02	04050	TELEMEDICINE	0	0	0	249	90.02
91.00	09100	EMERGENCY	0	26,338	0	152,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209	446,649	0	3,222,200	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,985	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	18,266	192.00
192.01	19201	FITNESS CENTER	0	0	0	17,073	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01			
192.04	19204	VACANT SPACE	413	0	0	0	26,820	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	622	446,649	0	3,239,273	22,616,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet B Part I Date/Time Prepared: 9/26/2018 10:11 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	6.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,585,988				5.00
6.00	00600	MAINTENANCE & REPAIRS	215,195	1,355,622			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,774	8,226	183,187		8.00
9.00	00900	HOUSEKEEPING	94,650	16,453	0	612,700	9.00
10.00	01000	DIETARY	118,100	77,397	0	36,229	857,596
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	102,986	8,072	0	3,778	0
14.00	01400	CENTRAL SERVICES & SUPPLY	14,673	26,455	0	12,384	0
15.00	01500	PHARMACY	396,541	26,069	0	12,203	0
16.00	01600	MEDICAL RECORDS & LIBRARY	88,542	26,243	0	12,284	0
17.00	01700	SOCIAL SERVICE	11,424	1,835	0	859	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	56,196	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	471,537	182,678	183,187	85,512	857,596
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	120,866	179,106	0	83,839	0
53.00	05300	ANESTHESIOLOGY	1,492	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,976	107,077	0	50,123	0
54.01	05401	ONCOLOGY	71,871	53,297	0	24,948	0
56.00	05600	RADIOISOTOPE	35,950	5,716	0	2,676	0
57.00	05700	CT SCAN	36,687	17,592	0	8,235	0
58.00	05800	MRI	33,458	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	258,023	52,293	0	24,478	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	86,881	59,032	0	27,633	0
66.00	06600	PHYSICAL THERAPY	96,615	103,080	0	48,252	0
67.00	06700	OCCUPATIONAL THERAPY	32,978	16,453	0	7,701	0
68.00	06800	SPEECH PATHOLOGY	17,291	2,066	0	967	0
69.00	06900	ELECTROCARDIOLOGY	2,218	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	397	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,479	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,262	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	74,541	39,567	0	18,521	0
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0
76.02	03030	SLEEP STUDY	12,694	8,979	0	4,203	0
76.97	07697	CARDIAC REHABILITATION	10,262	4,287	0	2,007	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	540,146	195,502	0	91,515	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	17,219	2,510	0	1,175	0
90.01	09002	COUMADIN, CHF/COPD CLINIC	4,359	0	0	0	0
90.02	04050	TELEMEDICINE	455	0	0	0	0
91.00	09100	EMERGENCY	316,543	113,604	0	53,178	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,566,281	1,333,589	183,187	612,700	857,596
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,073	8,091	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,447	13,015	0	0	0
192.01	19201	FITNESS CENTER	14,187	927	0	0	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	LEASED SPACE	0	0	0	0	0
192.04	19204	VACANT SPACE	0	0	0	0	0
192.05	19205	MEALS ON WHEELS	0	0	0	0	0
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
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)	3,585,988	1,355,622	183,187	612,700	857,596	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
13.00	01300	0	660,610				13.00
14.00	01400	0	0	131,274			14.00
15.00	01500	0	0	1,235	2,537,518		15.00
16.00	01600	0	0	439	0	596,736	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	416,436	10,084	0	31,182	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	39,022	7,579	0	13,185	50.00
53.00	05300	0	0	544	0	10,547	53.00
54.00	05400	0	0	7,433	0	43,399	54.00
54.01	05401	0	62,728	0	0	6,708	54.01
56.00	05600	0	0	576	0	8,021	56.00
57.00	05700	0	0	1,729	0	80,831	57.00
58.00	05800	0	0	0	0	18,729	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	43,680	0	122,477	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	2,493	0	10,658	65.00
66.00	06600	0	0	321	0	29,956	66.00
67.00	06700	0	0	81	0	9,709	67.00
68.00	06800	0	0	0	0	1,408	68.00
69.00	06900	0	0	57	0	4,455	69.00
70.00	07000	0	0	140	0	43	70.00
71.00	07100	0	0	32,586	0	3,526	71.00
72.00	07200	0	0	4,098	0	1,233	72.00
73.00	07300	0	0	0	2,537,518	89,651	73.00
76.00	03950	0	0	252	0	11,017	76.00
76.01	03020	0	0	0	0	6,075	76.01
76.02	03030	0	0	0	0	10,714	76.02
76.97	07697	0	0	14	0	2,474	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	8,056	0	39,748	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	2,620	90.00
90.01	09002	0	0	167	0	2,631	90.01
90.02	04050	0	0	0	0	30	90.02
91.00	09100	0	142,424	9,513	0	35,709	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		0	660,610	131,077	2,537,518	596,736	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	197	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	660,610	131,274	2,537,518	596,736	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	74,660					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	354,007				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,660	0	4,811,782	-32,070	4,779,712	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,084,129	0	1,084,129	50.00
53.00	05300	ANESTHESIOLOGY	0	354,007	374,498	0	374,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,335,490	0	1,335,490	54.00
54.01	05401	ONCOLOGY	0	0	600,430	0	600,430	54.01
56.00	05600	RADIO SOTOPE	0	0	243,457	0	243,457	56.00
57.00	05700	CT SCAN	0	0	339,499	0	339,499	57.00
58.00	05800	MRI	0	0	229,497	0	229,497	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,868,346	0	1,868,346	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	647,121	0	647,121	65.00
66.00	06600	PHYSICAL THERAPY	0	0	790,235	0	790,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	241,689	0	241,689	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	113,364	0	113,364	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,484	0	18,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,683	0	2,683	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	121,025	0	121,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38,477	0	38,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,627,169	0	2,627,169	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	538,929	0	538,929	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	6,075	32,070	38,145	76.01
76.02	03030	SLEEP STUDY	0	0	103,862	0	103,862	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	73,430	0	73,430	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,737,492	0	3,737,492	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	114,777	0	114,777	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	30,256	0	30,256	90.01
90.02	04050	TELEMEDICINE	0	0	2,894	0	2,894	90.02
91.00	09100	EMERGENCY	0	0	2,348,489	0	2,348,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,660	354,007	22,443,579	0	22,443,579	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,149	0	21,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	34,728	0	34,728	192.00
192.01	19201	FITNESS CENTER	0	0	90,494	0	90,494	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part I
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
192.04	19204	VACANT SPACE	0	0	26,820	0	26,820	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,660	354,007	22,616,770	0	22,616,770	202.00

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	2	SQUARE FEET	1.01
1.02	NEW CAP REL COSTS-PT BLDG	3	SQUARE FEET	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	4	SQUARE FEET	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	22	SQUARE FEET	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	25	SQUARE FEET	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	25	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	6	GROSS SALARIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	11	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	12	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	25	SQUARE FEET	9.00
10.00	DIETARY	12	PATIENT DAYS	10.00
11.00	CAFETERIA	15	SALARIES	11.00
13.00	NURSING ADMINISTRATION	16	NURSING SALARIES	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUIS.	14.00
15.00	PHARMACY	18	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	19	GROSS PATIENT REVENUE	16.00
17.00	SOCIAL SERVICE	12	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	21	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part II
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	545,470	0	11	2,451
6.00	00600	MAINTENANCE & REPAIRS	0	170,961	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,168	0	0	0
9.00	00900	HOUSEKEEPING	0	22,337	0	0	0
10.00	01000	DIETARY	0	105,078	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	10,959	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,917	0	0	0
15.00	01500	PHARMACY	0	35,393	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,629	0	0	0
17.00	01700	SOCIAL SERVICE	0	2,491	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	248,013	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	243,162	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,373	0	0	0
54.01	05401	ONCOLOGY	0	72,359	0	0	0
56.00	05600	RADIOISOTOPE	0	7,760	0	0	0
57.00	05700	CT SCAN	0	23,884	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	70,996	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	80,145	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	493	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	79	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	10	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
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	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	0	24,146	0	0	0
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0
76.02	03030	SLEEP STUDY	0	12,191	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	5,820	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	265,421	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	3,408	0	0	0
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0
90.02	04050	TELEMEDICINE	0	0	0	0	0
91.00	09100	EMERGENCY	0	154,234	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,332,315	0	593	2,451
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,985	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,670	0	0	0
192.01	19201	FITNESS CENTER	0	0	0	4	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part II
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
				1.00	1.01	1.02	1.03	
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	125	12,378	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,360,970	0	722	14,829	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am
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Cost Center Description		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG		
		1.04	2.00	2.01		
		2A			4.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG				1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG				1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG				1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG				1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	108,277	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	29,194	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,907	0	8.00
9.00	00900	HOUSEKEEPING	0	3,814	0	9.00
10.00	01000	DIETARY	0	17,944	0	10.00
11.00	01100	CAFETERIA	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,871	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,133	0	14.00
15.00	01500	PHARMACY	0	6,044	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,084	0	16.00
17.00	01700	SOCIAL SERVICE	0	425	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	42,352	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,524	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,825	0	54.00
54.01	05401	ONCOLOGY	0	12,356	0	54.01
56.00	05600	RADIO SOTOPE	0	1,325	0	56.00
57.00	05700	CT SCAN	0	4,079	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	12,124	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,686	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,814	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	479	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	209	9,173	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	2,082	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	994	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	45,325	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	582	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	90.02
91.00	09100	EMERGENCY	0	26,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209	446,649	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	4	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part II
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01			
192.04	19204	VACANT SPACE	413	0	0	12,916	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	622	446,649	0	2,823,792	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	6.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	656,209				5.00
6.00	00600	MAINTENANCE & REPAIRS	39,379	239,534			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,082	1,454	19,611		8.00
9.00	00900	HOUSEKEEPING	17,320	2,907	0	46,378	9.00
10.00	01000	DIETARY	21,611	13,676	0	2,742	161,051
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	18,846	1,426	0	286	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,685	4,675	0	937	0
15.00	01500	PHARMACY	72,564	4,606	0	924	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,202	4,637	0	930	0
17.00	01700	SOCIAL SERVICE	2,091	324	0	65	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	10,283	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	86,287	32,279	19,611	6,473	161,051
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,118	31,647	0	6,346	0
53.00	05300	ANESTHESIOLOGY	273	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,751	18,920	0	3,794	0
54.01	05401	ONCOLOGY	13,152	9,417	0	1,888	0
56.00	05600	RADIOISOTOPE	6,579	1,010	0	203	0
57.00	05700	CT SCAN	6,713	3,108	0	623	0
58.00	05800	MRI	6,123	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	47,216	9,240	0	1,853	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	15,898	10,431	0	2,092	0
66.00	06600	PHYSICAL THERAPY	17,680	18,214	0	3,652	0
67.00	06700	OCCUPATIONAL THERAPY	6,035	2,907	0	583	0
68.00	06800	SPEECH PATHOLOGY	3,164	365	0	73	0
69.00	06900	ELECTROCARDIOLOGY	406	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	73	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,467	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	963	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	13,640	6,991	0	1,402	0
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0
76.02	03030	SLEEP STUDY	2,323	1,587	0	318	0
76.97	07697	CARDIAC REHABILITATION	1,878	757	0	152	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	98,844	34,545	0	6,928	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	3,151	444	0	89	0
90.01	09002	COUMADIN, CHF/COPD CLINIC	798	0	0	0	0
90.02	04050	TELEMEDICINE	83	0	0	0	0
91.00	09100	EMERGENCY	57,925	20,073	0	4,025	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	652,603	235,640	19,611	46,378	161,051
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	379	1,430	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	631	2,300	0	0	0
192.01	19201	FITNESS CENTER	2,596	164	0	0	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	LEASED SPACE	0	0	0	0	0
192.04	19204	VACANT SPACE	0	0	0	0	0
192.05	19205	MEALS ON WHEELS	0	0	0	0	0
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1307			Period: From 05/01/2017 To 04/30/2018		Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	6.00	8.00	9.00	10.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	656,209	239,534	19,611	46,378	161,051		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	33,388				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	50,347			14.00
15.00	01500	PHARMACY	0	0	474	120,005		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	168	0	63,650	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	21,048	3,867	0	3,325	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,972	2,907	0	1,406	50.00
53.00	05300	ANESTHESIOLOGY	0	0	209	0	1,125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,851	0	4,628	54.00
54.01	05401	ONCOLOGY	0	3,170	0	0	715	54.01
56.00	05600	RADIOISOTOPE	0	0	221	0	855	56.00
57.00	05700	CT SCAN	0	0	663	0	8,620	57.00
58.00	05800	MRI	0	0	0	0	1,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	16,751	0	13,073	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	956	0	1,137	65.00
66.00	06600	PHYSICAL THERAPY	0	0	123	0	3,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	31	0	1,035	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	150	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	22	0	475	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	54	0	5	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	12,498	0	376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,572	0	132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	120,005	9,561	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	97	0	1,175	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	648	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	1,143	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	5	0	264	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,090	0	4,239	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	279	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	64	0	281	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	3	90.02
91.00	09100	EMERGENCY	0	7,198	3,648	0	3,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,388	50,271	120,005	63,650	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	76	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	33,388	50,347	120,005	63,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet B Part II Date/Time Prepared: 9/26/2018 10:11 am		
Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			17.00	19.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	5,396				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	10,283			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,396		629,702	0	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0		351,082	0	50.00
53.00	05300	ANESTHESIOLOGY	0		1,607	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		233,142	0	54.00
54.01	05401	ONCOLOGY	0		113,057	0	54.01
56.00	05600	RADIO SOTOPE	0		17,953	0	56.00
57.00	05700	CT SCAN	0		47,690	0	57.00
58.00	05800	MRI	0		8,120	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	59.00
60.00	06000	LABORATORY	0		171,253	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0		124,345	0	65.00
66.00	06600	PHYSICAL THERAPY	0		67,255	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		14,484	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		4,241	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		903	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		132	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		15,341	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		2,667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		129,566	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0		56,833	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0		648	0	76.01
76.02	03030	SLEEP STUDY	0		19,644	0	76.02
76.97	07697	CARDIAC REHABILITATION	0		9,870	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		458,392	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	89.00
90.00	09000	CLINIC	0		7,953	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0		1,143	0	90.01
90.02	04050	TELEMEDICINE	0		86	0	90.02
91.00	09100	EMERGENCY	0		277,249	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,396	0	2,764,358	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		12,794	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		20,601	0	192.00
192.01	19201	FITNESS CENTER	0		2,840	0	192.01
192.02	19202	RETAIL PHARMACY	0		0	0	192.02
192.03	19203	LEASED SPACE	0		0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B
Part II
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
192.04	19204	VACANT SPACE	0		12,916	0	12,916	192.04
192.05	19205	MEALS ON WHEELS	0		0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0		0	0	0	192.06
200.00		Cross Foot Adjustments		10,283	10,283	0	10,283	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,396	10,283	2,823,792	0	2,823,792	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		CAPITAL RELATED COSTS					15 N MAIN BLDG (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)			
		1.00	1.01	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	90,055					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0		7,828			1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	0	0	19,702		1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	3,360	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,806	0	123	3,256	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,521	0	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	852	0	0	0	0	9.00
10.00	01000	DIETARY	4,008	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	0	0	0	14.00
15.00	01500	PHARMACY	1,350	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	95	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,460	0	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,275	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	0	0	0	54.00
54.01	05401	ONCOLOGY	2,760	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	296	0	0	0	0	56.00
57.00	05700	CT SCAN	911	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,057	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,338	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	852	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	107	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	921	0	0	0	1,128	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	465	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	222	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,124	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	130	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,962	0	6,420	3,256	1,128	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	419	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	674	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	48	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
192.04	19204	VACANT SPACE	0	0	1,360	16,446	2,232	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,360,970	0	722	14,829	622	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.216979	0.000000	0.092233	0.752665	0.185119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
	2.00	2.01				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02 00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03 00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04 00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00 00200	CAP REL COSTS-MVBLE EQUIP	99,766				2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	99,766			2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,959,187		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,185	24,185	1,434,903	-3,585,988	19,003,962
6.00 00600	MAINTENANCE & REPAIRS	6,521	6,521	286,729	0	1,140,427
8.00 00800	LAUNDRY & LINEN SERVICE	426	426	30,310	0	147,187
9.00 00900	HOUSEKEEPING	852	852	330,867	0	501,597
10.00 01000	DIETARY	4,008	4,008	307,796	0	625,870
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	418	418	390,708	0	545,774
14.00 01400	CENTRAL SERVICES & SUPPLY	1,370	1,370	24,184	0	77,762
15.00 01500	PHARMACY	1,350	1,350	305,339	0	2,101,470
16.00 01600	MEDICAL RECORDS & LIBRARY	1,359	1,359	307,799	0	469,228
17.00 01700	SOCIAL SERVICE	95	95	40,570	0	60,542
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	297,811
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,460	9,460	1,684,377	0	2,498,910
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,275	9,275	128,593	0	640,532
53.00 05300	ANESTHESIOLOGY	0	0	0	0	7,908
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,545	5,545	475,637	0	948,482
54.01 05401	ONCOLOGY	2,760	2,760	206,713	0	380,878
56.00 05600	RADIOISOTOPE	296	296	71,333	0	190,518
57.00 05700	CT SCAN	911	911	55,534	0	194,425
58.00 05800	MRI	0	0	0	0	177,310
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	2,708	2,708	536,253	0	1,367,395
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	3,057	3,057	235,851	0	460,424
66.00 06600	PHYSICAL THERAPY	5,338	5,338	348,834	0	512,011
67.00 06700	OCCUPATIONAL THERAPY	852	852	129,001	0	174,767
68.00 06800	SPEECH PATHOLOGY	107	107	77,136	0	91,632
69.00 06900	ELECTROCARDIOLOGY	0	0	3,075	0	11,754
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	377	0	2,103
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71,434
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,884
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03950	SENIOR LIFE SOLUTIONS	2,049	2,049	193,259	0	395,031
76.01 03020	OP IV THERAPY/NURSING	0	0	0	0	0
76.02 03030	SLEEP STUDY	465	465	0	0	67,272
76.97 07697	CARDIAC REHABILITATION	222	222	34,152	0	54,386
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	10,124	10,124	1,767,079	0	2,862,525
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	130	130	13,607	0	91,253
90.01 09002	COUMADIN, CHF/COPD CLINIC	0	0	16,575	0	23,099
90.02 04050	TELEMEDICINE	0	0	765	0	2,409
91.00 09100	EMERGENCY	5,883	5,883	469,341	0	1,677,518
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	99,766	99,766	9,906,697	-3,585,988	18,899,528
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	10,985
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	18,266
192.01 19201	FITNESS CENTER	0	0	52,490	0	75,183

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
			2.00	2.01	4.00	5A	5.00	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	-26,820	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	446,649	0	3,239,273		3,585,988	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.476966	0.000000	0.325255		0.188697	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		656,209	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.034530	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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	70,201					6.00
8.00	00800	426	3,294				8.00
9.00	00900	852	0	67,782			9.00
10.00	01000	4,008	0	4,008	3,294		10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	418	0	418	0	0	13.00
14.00	01400	1,370	0	1,370	0	0	14.00
15.00	01500	1,350	0	1,350	0	0	15.00
16.00	01600	1,359	0	1,359	0	0	16.00
17.00	01700	95	0	95	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,460	3,294	9,460	3,294	0	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,275	0	9,275	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	5,545	0	5,545	0	0	54.00
54.01	05401	2,760	0	2,760	0	0	54.01
56.00	05600	296	0	296	0	0	56.00
57.00	05700	911	0	911	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,708	0	2,708	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,057	0	3,057	0	0	65.00
66.00	06600	5,338	0	5,338	0	0	66.00
67.00	06700	852	0	852	0	0	67.00
68.00	06800	107	0	107	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	2,049	0	2,049	0	0	76.00
76.01	03020	0	0	0	0	0	76.01
76.02	03030	465	0	465	0	0	76.02
76.97	07697	222	0	222	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	10,124	0	10,124	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	130	0	130	0	0	90.00
90.01	09002	0	0	0	0	0	90.01
90.02	04050	0	0	0	0	0	90.02
91.00	09100	5,883	0	5,883	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		69,060	3,294	67,782	3,294	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	419	0	0	0	0	190.00
192.00	19200	674	0	0	0	0	192.00
192.01	19201	48	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
		6.00	8.00	9.00	10.00	11.00	
192.05	19205 MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206 15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,355,622	183,187	612,700	857,596	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19.310580	55.612325	9.039273	260.350941	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	239,534	19,611	46,378	161,051	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.412117	5.953552	0.684223	48.892228	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	SOCIAL SERVICE (PATIENT DA YS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
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	2,176,956					13.00
14.00	01400	0	893,131				14.00
15.00	01500	0	8,403	1,586,132			15.00
16.00	01600	0	2,986	0	42,146,328		16.00
17.00	01700	0	0	0	0	3,294	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,372,309	68,604	0	2,202,272	3,294	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	128,593	51,562	0	931,191	0	50.00
53.00	05300	0	3,701	0	744,914	0	53.00
54.00	05400	0	50,574	0	3,065,108	0	54.00
54.01	05401	206,713	0	0	473,777	0	54.01
56.00	05600	0	3,916	0	566,474	0	56.00
57.00	05700	0	11,760	0	5,708,777	0	57.00
58.00	05800	0	0	0	1,322,756	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	297,180	0	8,651,298	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	16,963	0	752,707	0	65.00
66.00	06600	0	2,182	0	2,115,679	0	66.00
67.00	06700	0	549	0	685,682	0	67.00
68.00	06800	0	0	0	99,423	0	68.00
69.00	06900	0	389	0	314,631	0	69.00
70.00	07000	0	953	0	3,065	0	70.00
71.00	07100	0	221,704	0	249,001	0	71.00
72.00	07200	0	27,884	0	87,094	0	72.00
73.00	07300	0	0	1,586,132	6,331,727	0	73.00
76.00	03950	0	1,717	0	778,110	0	76.00
76.01	03020	0	0	0	429,032	0	76.01
76.02	03030	0	0	0	756,714	0	76.02
76.97	07697	0	97	0	174,707	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	54,812	0	2,807,239	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	185,038	0	90.00
90.01	09002	0	1,133	0	185,814	0	90.01
90.02	04050	0	0	0	2,113	0	90.02
91.00	09100	469,341	64,719	0	2,521,985	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		2,176,956	891,788	1,586,132	42,146,328	3,294	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	1,343	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
192.04	19204 VACANT SPACE	0	0	0	0	0	192.04
192.05	19205 MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206 15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	660,610	131,274	2,537,518	596,736	74,660	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.303456	0.146982	1.599815	0.014159	22.665452	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	33,388	50,347	120,005	63,650	5,396	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.015337	0.056371	0.075659	0.001510	1.638130	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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
15.00	01500	PHARMACY	15.00
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
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ONCOLOGY	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
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	SENIOR LIFE SOLUTIONS	76.00
76.01	03020	OP IV THERAPY/NURSING	76.01
76.02	03030	SLEEP STUDY	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	90.01
90.02	04050	TELEMEDICINE	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
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
192.01	19201	FITNESS CENTER	192.01
192.02	19202	RETAIL PHARMACY	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	VACANT SPACE	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
192.05	19205 MEALS ON WHEELS	0	192.05
192.06	19206 15 N MAIN BUILDING	0	192.06
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)	354,007	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3,540.070000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	10,283	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	102.830000	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

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-2
Date/Time Prepared:
9/26/2018 10:11 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	RECLASS OP NURSING PROC DONE IN IP		1 76.01	32,070	7.00
8.00	RECLASS OP NURSING PROC DONE IN OP		1 30.00	-32,070	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet C
Part I
Date/Time Prepared:
9/26/2018 10:11 am

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	4,779,712		4,779,712	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,084,129		1,084,129	0	0	50.00
53.00	05300	ANESTHESIOLOGY	374,498		374,498	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,335,490		1,335,490	0	0	54.00
54.01	05401	ONCOLOGY	600,430		600,430	0	0	54.01
56.00	05600	RADIOISOTOPE	243,457		243,457	0	0	56.00
57.00	05700	CT SCAN	339,499		339,499	0	0	57.00
58.00	05800	MRI	229,497		229,497	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,868,346		1,868,346	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	647,121	0	647,121	0	0	65.00
66.00	06600	PHYSICAL THERAPY	790,235	0	790,235	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,689	0	241,689	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	113,364	0	113,364	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,484		18,484	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,683		2,683	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,025		121,025	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,477		38,477	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,627,169		2,627,169	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	538,929		538,929	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	38,145		38,145	0	0	76.01
76.02	03030	SLEEP STUDY	103,862		103,862	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	73,430		73,430	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,737,492		3,737,492	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	114,777		114,777	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	30,256		30,256	0	0	90.01
90.02	04050	TELEMEDICINE	2,894		2,894	0	0	90.02
91.00	09100	EMERGENCY	2,348,489		2,348,489	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	401,957		401,957	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,845,536	0	22,845,536	0	0	200.00
201.00		Less Observation Beds	401,957		401,957			201.00
202.00		Total (see instructions)	22,443,579	0	22,443,579	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet C
Part I
Date/Time Prepared:
9/26/2018 10:11 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	1,864,545		1,864,545		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,880	923,311	931,191	1.164239	50.00
53.00	05300	ANESTHESIOLOGY	6,797	738,117	744,914	0.502740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,622	2,832,486	3,065,108	0.435707	54.00
54.01	05401	ONCOLOGY	18,610	455,167	473,777	1.267326	54.01
56.00	05600	RADIOISOTOPE	24,262	542,212	566,474	0.429776	56.00
57.00	05700	CT SCAN	346,945	5,361,832	5,708,777	0.059470	57.00
58.00	05800	MRI	35,154	1,287,602	1,322,756	0.173499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	751,407	7,899,891	8,651,298	0.215961	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	309,058	443,649	752,707	0.859725	65.00
66.00	06600	PHYSICAL THERAPY	416,721	1,698,958	2,115,679	0.373514	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,636	361,046	685,682	0.352480	67.00
68.00	06800	SPEECH PATHOLOGY	31,509	67,914	99,423	1.140219	68.00
69.00	06900	ELECTROCARDIOLOGY	12,775	301,856	314,631	0.058748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	341	2,724	3,065	0.875367	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,304	99,697	249,001	0.486042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	87,094	87,094	0.441787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768,897	5,562,830	6,331,727	0.414921	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	778,110	778,110	0.692613	76.00
76.01	03020	OP IV THERAPY/NURSING	0	429,032	429,032	0.088909	76.01
76.02	03030	SLEEP STUDY	0	756,714	756,714	0.137254	76.02
76.97	07697	CARDIAC REHABILITATION	0	174,707	174,707	0.420304	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,807,239	2,807,239		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	788	184,250	185,038	0.620289	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	185,814	185,814	0.162829	90.01
90.02	04050	TELEMEDICINE	0	2,113	2,113	1.369617	90.02
91.00	09100	EMERGENCY	79,579	2,442,406	2,521,985	0.931207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	337,727	337,727	1.190183	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,381,830	36,764,498	42,146,328		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,381,830	36,764,498	42,146,328		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet C Part I Date/Time Prepared: 9/26/2018 10:11 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ONCOLOGY	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
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 SENIOR LIFE SOLUTIONS	0.000000		76.00
76.01	03020 OP IV THERAPY/NURSING	0.000000		76.01
76.02	03030 SLEEP STUDY	0.000000		76.02
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	0.000000		90.01
90.02	04050 TELEMEDICINE	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet C
Part I
Date/Time Prepared:
9/26/2018 10:11 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	4,779,712		4,779,712	0	4,779,712 30.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,084,129		1,084,129	0	1,084,129 50.00
53.00	05300 ANESTHESIOLOGY	374,498		374,498	0	374,498 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,335,490		1,335,490	0	1,335,490 54.00
54.01	05401 ONCOLOGY	600,430		600,430	0	600,430 54.01
56.00	05600 RADIOISOTOPE	243,457		243,457	0	243,457 56.00
57.00	05700 CT SCAN	339,499		339,499	0	339,499 57.00
58.00	05800 MRI	229,497		229,497	0	229,497 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	1,868,346		1,868,346	0	1,868,346 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	647,121	0	647,121	0	647,121 65.00
66.00	06600 PHYSICAL THERAPY	790,235	0	790,235	0	790,235 66.00
67.00	06700 OCCUPATIONAL THERAPY	241,689	0	241,689	0	241,689 67.00
68.00	06800 SPEECH PATHOLOGY	113,364	0	113,364	0	113,364 68.00
69.00	06900 ELECTROCARDIOLOGY	18,484		18,484	0	18,484 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,683		2,683	0	2,683 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	121,025		121,025	0	121,025 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	38,477		38,477	0	38,477 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,627,169		2,627,169	0	2,627,169 73.00
76.00	03950 SENIOR LIFE SOLUTIONS	538,929		538,929	0	538,929 76.00
76.01	03020 OP IV THERAPY/NURSING	38,145		38,145	0	38,145 76.01
76.02	03030 SLEEP STUDY	103,862		103,862	0	103,862 76.02
76.97	07697 CARDIAC REHABILITATION	73,430		73,430	0	73,430 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	3,737,492		3,737,492	0	3,737,492 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00	09000 CLINIC	114,777		114,777	0	114,777 90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	30,256		30,256	0	30,256 90.01
90.02	04050 TELEMEDICINE	2,894		2,894	0	2,894 90.02
91.00	09100 EMERGENCY	2,348,489		2,348,489	0	2,348,489 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	401,957		401,957	0	401,957 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0		0	0	0 109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0 110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0 111.00
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	22,845,536	0	22,845,536	0	22,845,536 200.00
201.00	Less Observation Beds	401,957		401,957	0	401,957 201.00
202.00	Total (see instructions)	22,443,579	0	22,443,579	0	22,443,579 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet C
Part I
Date/Time Prepared:
9/26/2018 10:11 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,864,545		1,864,545		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,880	923,311	931,191	1.164239	50.00
53.00	05300	ANESTHESIOLOGY	6,797	738,117	744,914	0.502740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,622	2,832,486	3,065,108	0.435707	54.00
54.01	05401	ONCOLOGY	18,610	455,167	473,777	1.267326	54.01
56.00	05600	RADIOISOTOPE	24,262	542,212	566,474	0.429776	56.00
57.00	05700	CT SCAN	346,945	5,361,832	5,708,777	0.059470	57.00
58.00	05800	MRI	35,154	1,287,602	1,322,756	0.173499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	751,407	7,899,891	8,651,298	0.215961	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	309,058	443,649	752,707	0.859725	65.00
66.00	06600	PHYSICAL THERAPY	416,721	1,698,958	2,115,679	0.373514	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,636	361,046	685,682	0.352480	67.00
68.00	06800	SPEECH PATHOLOGY	31,509	67,914	99,423	1.140219	68.00
69.00	06900	ELECTROCARDIOLOGY	12,775	301,856	314,631	0.058748	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	341	2,724	3,065	0.875367	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,304	99,697	249,001	0.486042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	87,094	87,094	0.441787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768,897	5,562,830	6,331,727	0.414921	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	778,110	778,110	0.692613	76.00
76.01	03020	OP IV THERAPY/NURSING	0	429,032	429,032	0.088909	76.01
76.02	03030	SLEEP STUDY	0	756,714	756,714	0.137254	76.02
76.97	07697	CARDIAC REHABILITATION	0	174,707	174,707	0.420304	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,807,239	2,807,239	1.331376	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	788	184,250	185,038	0.620289	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	185,814	185,814	0.162829	90.01
90.02	04050	TELEMEDICINE	0	2,113	2,113	1.369617	90.02
91.00	09100	EMERGENCY	79,579	2,442,406	2,521,985	0.931207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	337,727	337,727	1.190183	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,381,830	36,764,498	42,146,328		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,381,830	36,764,498	42,146,328		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet C Part I Date/Time Prepared: 9/26/2018 10:11 am
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital
					Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ONCOLOGY	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
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	SENIOR LIFE SOLUTIONS	0.000000		76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000		76.01
76.02	03030	SLEEP STUDY	0.000000		76.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.000000		90.01
90.02	04050	TELEMEDICINE	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part II Date/Time Prepared: 9/26/2018 10:11 am
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	351,082	931,191	0.377025	4,583	1,728	50.00
53.00	05300 ANESTHESIOLOGY	1,607	744,914	0.002157	3,863	8	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	233,142	3,065,108	0.076063	135,899	10,337	54.00
54.01	05401 ONCOLOGY	113,057	473,777	0.238629	7,393	1,764	54.01
56.00	05600 RADIOISOTOPE	17,953	566,474	0.031693	12,131	384	56.00
57.00	05700 CT SCAN	47,690	5,708,777	0.008354	252,495	2,109	57.00
58.00	05800 MRI	8,120	1,322,756	0.006139	19,557	120	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	171,253	8,651,298	0.019795	405,992	8,037	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	124,345	752,707	0.165197	158,505	26,185	65.00
66.00	06600 PHYSICAL THERAPY	67,255	2,115,679	0.031789	43,745	1,391	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,484	685,682	0.021123	26,306	556	67.00
68.00	06800 SPEECH PATHOLOGY	4,241	99,423	0.042656	7,103	303	68.00
69.00	06900 ELECTROCARDIOLOGY	903	314,631	0.002870	9,450	27	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	132	3,065	0.043067	340	15	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,341	249,001	0.061610	69,890	4,306	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,667	87,094	0.030622	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	129,566	6,331,727	0.020463	290,515	5,945	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	56,833	778,110	0.073040	0	0	76.00
76.01	03020 OP IV THERAPY/NURSING	648	429,032	0.001510	0	0	76.01
76.02	03030 SLEEP STUDY	19,644	756,714	0.025960	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	9,870	174,707	0.056495	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	458,392	2,807,239	0.163289	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	7,953	185,038	0.042980	0	0	90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	1,143	185,814	0.006151	0	0	90.01
90.02	04050 TELEMEDICINE	86	2,113	0.040700	0	0	90.02
91.00	09100 EMERGENCY	277,249	2,521,985	0.109933	240	26	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	52,956	337,727	0.156801	0	0	92.00
200.00	Total (lines 50 through 199)	2,187,612	40,281,783		1,448,007	63,241	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part IV Date/Time Prepared: 9/26/2018 10:11 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	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	354,007	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.00	
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01	
76.02	03030	SLEEP STUDY	0	0	0	0	0	76.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0	90.01	
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	354,007	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part IV Date/Time Prepared: 9/26/2018 10:11 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	0	0	931,191	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	354,007	0	744,914	0.475232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,065,108	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	473,777	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	566,474	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	5,708,777	0.000000	57.00
58.00	05800	MRI	0	0	0	1,322,756	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	8,651,298	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	752,707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,115,679	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	685,682	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	99,423	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	314,631	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,065	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	249,001	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	87,094	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,331,727	0.000000	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	778,110	0.000000	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	429,032	0.000000	76.01
76.02	03030	SLEEP STUDY	0	0	0	756,714	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	174,707	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,807,239	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	185,038	0.000000	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	185,814	0.000000	90.01
90.02	04050	TELEMEDICINE	0	0	0	2,113	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,521,985	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	337,727	0.000000	92.00
200.00		Total (lines 50 through 199)	0	354,007	0	40,281,783		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part IV Date/Time Prepared: 9/26/2018 10:11 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	4,583	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	3,863	1,836	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	135,899	0	0	0	54.00
54.01	05401 ONCOLOGY	0.000000	7,393	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	12,131	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	252,495	0	0	0	57.00
58.00	05800 MRI	0.000000	19,557	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	405,992	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	158,505	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	43,745	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	26,306	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	7,103	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	9,450	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	340	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	69,890	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	290,515	0	0	0	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0	76.00
76.01	03020 OP IV THERAPY/NURSING	0.000000	0	0	0	0	76.01
76.02	03030 SLEEP STUDY	0.000000	0	0	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	0.000000	0	0	0	0	90.01
90.02	04050 TELEMEDICINE	0.000000	0	0	0	0	90.02
91.00	09100 EMERGENCY	0.000000	240	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,448,007	1,836	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part IV Date/Time Prepared: 9/26/2018 10:11 am
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Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
		21.00	24.00		
Title XVIII					
				Hospital	Cost
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ONCOLOGY	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	SENIOR LIFE SOLUTIONS	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	76.01
76.02	03030	SLEEP STUDY	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 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	1.164239	0	538,940	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.502740	0	411,450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.435707	0	1,325,418	0	0	54.00
54.01	05401	ONCOLOGY	1.267326	0	273,998	0	0	54.01
56.00	05600	RADIOISOTOPE	0.429776	0	284,224	0	0	56.00
57.00	05700	CT SCAN	0.059470	0	2,618,127	0	0	57.00
58.00	05800	MRI	0.173499	0	490,854	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.215961	0	3,932,102	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.859725	0	231,160	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373514	0	705,521	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352480	0	158,095	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.140219	0	19,410	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058748	0	169,400	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.875367	0	681	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	0	64,501	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	58,896	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414921	0	3,610,847	318	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.692613	0	772,201	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.088909	0	261,949	0	0	76.01
76.02	03030	SLEEP STUDY	0.137254	0	230,011	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.420304	0	101,284	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.620289	0	152,883	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.162829	0	155,528	0	0	90.01
90.02	04050	TELEMEDICINE	1.369617	0	1,328	0	0	90.02
91.00	09100	EMERGENCY	0.931207	0	1,040,383	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.190183	0	221,912	0	0	92.00
200.00		Subtotal (see instructions)		0	17,831,103	318	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	17,831,103	318	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 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	627,455	0	50.00
53.00 05300	ANESTHESIOLOGY	206,852	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	577,494	0	54.00
54.01 05401	ONCOLOGY	347,245	0	54.01
56.00 05600	RADIOISOTOPE	122,153	0	56.00
57.00 05700	CT SCAN	155,700	0	57.00
58.00 05800	MRI	85,163	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	849,181	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	198,734	0	65.00
66.00 06600	PHYSICAL THERAPY	263,522	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	55,725	0	67.00
68.00 06800	SPEECH PATHOLOGY	22,132	0	68.00
69.00 06900	ELECTROCARDIOLOGY	9,952	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	596	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,350	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	26,019	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,498,216	132	73.00
76.00 03950	SENIOR LIFE SOLUTIONS	534,836	0	76.00
76.01 03020	OP IV THERAPY/NURSING	23,290	0	76.01
76.02 03030	SLEEP STUDY	31,570	0	76.02
76.97 07697	CARDIAC REHABILITATION	42,570	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800	RURAL HEALTH CLINIC	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000	CLINIC	94,832	0	90.00
90.01 09002	COUMADIN, CHF/COPD CLINIC	25,324	0	90.01
90.02 04050	TELEMEDICINE	1,819	0	90.02
91.00 09100	EMERGENCY	968,812	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	264,116	0	92.00
200.00	Subtotal (see instructions)	7,064,658	132	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	7,064,658	132	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 am
Title XVIII		Swing Beds - SNF	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	1.164239	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.502740	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.435707	0	0	0	0	54.00
54.01 05401 ONCOLOGY	1.267326	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.429776	0	0	0	0	56.00
57.00 05700 CT SCAN	0.059470	0	0	0	0	57.00
58.00 05800 MRI	0.173499	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.215961	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.859725	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.373514	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.352480	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.140219	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.058748	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.875367	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.414921	0	0	0	0	73.00
76.00 03950 SENIOR LIFE SOLUTIONS	0.692613	0	0	0	0	76.00
76.01 03020 OP IV THERAPY/NURSING	0.088909	0	0	0	0	76.01
76.02 03030 SLEEP STUDY	0.137254	0	0	0	0	76.02
76.97 07697 CARDIAC REHABILITATION	0.420304	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00 09000 CLINIC	0.620289	0	0	0	0	90.00
90.01 09002 COUMADIN, CHF/COPD CLINIC	0.162829	0	0	0	0	90.01
90.02 04050 TELEMEDICINE	1.369617	0	0	0	0	90.02
91.00 09100 EMERGENCY	0.931207	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.190183	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: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ONCOLOGY	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
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 SENIOR LIFE SOLUTIONS	0	0		76.00
76.01 03020 OP IV THERAPY/NURSING	0	0		76.01
76.02 03030 SLEEP STUDY	0	0		76.02
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
90.01 09002 COUMADIN, CHF/COPD CLINIC	0	0		90.01
90.02 04050 TELEMEDICINE	0	0		90.02
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 am
		Title XIX	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	1.164239	0	73,701	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.502740	0	48,619	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.435707	0	402,138	0	0	54.00
54.01	05401	ONCOLOGY	1.267326	0	24,172	0	0	54.01
56.00	05600	RADIOISOTOPE	0.429776	0	53,838	0	0	56.00
57.00	05700	CT SCAN	0.059470	0	863,193	0	0	57.00
58.00	05800	MRI	0.173499	0	248,832	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.215961	0	928,030	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.859725	0	47,825	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373514	0	86,354	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352480	0	106,791	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.140219	0	31,722	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058748	0	38,869	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.875367	0	1,362	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	0	8,456	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	4,481	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414921	0	260,074	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.692613	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.088909	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.137254	0	115,946	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.420304	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1.331376				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.620289	0	18,683	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.162829	0	1,893	0	0	90.01
90.02	04050	TELEMEDICINE	1.369617	0	346	0	0	90.02
91.00	09100	EMERGENCY	0.931207	0	528,107	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.190183	0	88,838	0	0	92.00
200.00		Subtotal (see instructions)		0	3,982,270	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	3,982,270	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D Part V Date/Time Prepared: 9/26/2018 10:11 am
		Title XIX	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	85,806	0	50.00
53.00	05300	ANESTHESIOLOGY	24,443	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,214	0	54.00
54.01	05401	ONCOLOGY	30,634	0	54.01
56.00	05600	RADIOISOTOPE	23,138	0	56.00
57.00	05700	CT SCAN	51,334	0	57.00
58.00	05800	MRI	43,172	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	200,418	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	41,116	0	65.00
66.00	06600	PHYSICAL THERAPY	32,254	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,170	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,283	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,192	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,110	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,980	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,910	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	76.01
76.02	03030	SLEEP STUDY	15,914	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	11,589	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	308	0	90.01
90.02	04050	TELEMEDICINE	474	0	90.02
91.00	09100	EMERGENCY	491,777	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,733	0	92.00
200.00		Subtotal (see instructions)	1,524,611	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,524,611	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/26/2018 10:11 am
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,296	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,644	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,389	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		930	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)		429	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		123	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)		170	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,053	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)		791	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)		429	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		158.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,779,712	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)		19,115	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)		26,948	25.00
26.00	Total swing-bed cost (see instructions)		2,188,268	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,591,444	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,591,444	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)		1,576.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,659,854	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,659,854	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D-1 Date/Time Prepared: 9/26/2018 10:11 am
Title XVIII			Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					512,727 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,172,581 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,246,861 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					676,237 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,923,098 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)					255 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,576.30 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					401,957 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307		Period: From 05/01/2017 To 04/30/2018		Worksheet D-1 Date/Time Prepared: 9/26/2018 10:11 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	629,702	4,779,712	0.131745	401,957	52,956	90.00
91.00	Nursing School cost	0	4,779,712	0.000000	401,957	0	91.00
92.00	Allied health cost	0	4,779,712	0.000000	401,957	0	92.00
93.00	All other Medical Education	0	4,779,712	0.000000	401,957	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D-3 Date/Time Prepared: 9/26/2018 10:11 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		844,793	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.164239	4,583	50.00
53.00	05300	ANESTHESIOLOGY	0.502740	3,863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.435707	135,899	54.00
54.01	05401	ONCOLOGY	1.267326	7,393	54.01
56.00	05600	RADIOISOTOPE	0.429776	12,131	56.00
57.00	05700	CT SCAN	0.059470	252,495	57.00
58.00	05800	MRI	0.173499	19,557	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.215961	405,992	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.859725	158,505	65.00
66.00	06600	PHYSICAL THERAPY	0.373514	43,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.352480	26,306	67.00
68.00	06800	SPEECH PATHOLOGY	1.140219	7,103	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058748	9,450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.875367	340	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	69,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414921	290,515	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.692613	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.088909	0	76.01
76.02	03030	SLEEP STUDY	0.137254	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.420304	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.620289	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.162829	0	90.01
90.02	04050	TELEMEDICINE	1.369617	0	90.02
91.00	09100	EMERGENCY	0.931207	240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.190183	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,448,007	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,448,007	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2017 To 04/30/2018	Worksheet D-3 Date/Time Prepared: 9/26/2018 10:11 am
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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
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.164239	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.502740	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435707	35,511	15,472	54.00
54.01	05401 ONCOLOGY	1.267326	4,041	5,121	54.01
56.00	05600 RADIOISOTOPE	0.429776	4,150	1,784	56.00
57.00	05700 CT SCAN	0.059470	65,155	3,875	57.00
58.00	05800 MRI	0.173499	2,626	456	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.215961	194,918	42,095	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.859725	100,083	86,044	65.00
66.00	06600 PHYSICAL THERAPY	0.373514	307,089	114,702	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.352480	248,563	87,613	67.00
68.00	06800 SPEECH PATHOLOGY	1.140219	22,661	25,839	68.00
69.00	06900 ELECTROCARDIOLOGY	0.058748	2,625	154	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.875367	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	50,213	24,406	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414921	268,164	111,267	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0.692613	0	0	76.00
76.01	03020 OP IV THERAPY/NURSING	0.088909	0	0	76.01
76.02	03030 SLEEP STUDY	0.137254	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.420304	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.620289	413	256	90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	0.162829	0	0	90.01
90.02	04050 TELEMEDICINE	1.369617	0	0	90.02
91.00	09100 EMERGENCY	0.931207	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.190183	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,306,212	519,084	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,306,212		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet D-3 Date/Time Prepared: 9/26/2018 10:11 am
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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		107,340		30.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.164239	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.502740	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.435707	17,691	7,708	54.00
54.01	05401 ONCOLOGY	1.267326	270	342	54.01
56.00	05600 RADIOISOTOPE	0.429776	2,075	892	56.00
57.00	05700 CT SCAN	0.059470	29,295	1,742	57.00
58.00	05800 MRI	0.173499	2,626	456	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.215961	50,616	10,931	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.859725	16,912	14,540	65.00
66.00	06600 PHYSICAL THERAPY	0.373514	841	314	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.352480	648	228	67.00
68.00	06800 SPEECH PATHOLOGY	1.140219	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.058748	700	41	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.875367	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.486042	5,689	2,765	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.441787	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414921	43,362	17,992	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0.692613	0	0	76.00
76.01	03020 OP IV THERAPY/NURSING	0.088909	0	0	76.01
76.02	03030 SLEEP STUDY	0.137254	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.420304	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.331376	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	0.620289	0	0	90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	0.162829	0	0	90.01
90.02	04050 TELEMEDICINE	1.369617	0	0	90.02
91.00	09100 EMERGENCY	0.931207	30,814	28,694	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.190183	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		201,539	86,645	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		201,539		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/26/2018 10:11 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,064,790	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		0	2.00
3.00	OPPTS 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)		7,064,790	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)		7,135,438	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)		32,349	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,772,516	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)		4,330,573	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)		4,330,573	30.00
31.00	Primary payer payments		1,757	31.00
32.00	Subtotal (line 30 minus line 31)		4,328,816	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)		359,073	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		233,397	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		257,857	36.00
37.00	Subtotal (see instructions)		4,562,213	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)		4,562,213	40.00
40.01	Sequestration adjustment (see instructions)		91,244	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,650,746	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-179,777	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/26/2018 10:11 am
		Title XVIII	Hospital
			Cost
			Overrides
			1.00
112.00	WORKSHEET OVERRIDE VALUES Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part I Date/Time Prepared: 9/26/2018 10:11 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		2,070,161		4,650,746	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	04/19/2018	49,498		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)		49,498		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,119,659		4,650,746	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		152,476		179,777	6.02
7.00	Total Medicare program liability (see instructions)		1,967,183		4,470,969	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307
Component CCN: 14-Z307

Period:
From 05/01/2017
To 04/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
9/26/2018 10:11 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		2,479,987		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	04/19/2018	44,947		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)		44,947		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,524,934		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		150,738		0	6.02
7.00	Total Medicare program liability (see instructions)		2,374,196		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/26/2018 10:11 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
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2017 To 04/30/2018	Worksheet E-2 Date/Time Prepared: 9/26/2018 10:11 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)	1,942,329	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)	524,275	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,220	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,466,604	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,466,604	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,466,604	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	43,955	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,422,649	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)	2,422,649	0	19.00
19.01	Sequestration adjustment (see instructions)	48,453	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	2,524,934	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)	-150,738	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: 14-1307	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part V Date/Time Prepared: 9/26/2018 10:11 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,172,581	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)		2,172,581	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,194,307	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)		2,194,307	19.00
20.00	Deductibles (exclude professional component)		228,695	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,965,612	22.00
23.00	Coinurance		1,675	23.00
24.00	Subtotal (line 22 minus line 23)		1,963,937	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		66,758	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		43,393	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		51,718	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,007,330	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)		2,007,330	30.00
30.01	Sequestration adjustment (see instructions)		40,147	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		2,119,659	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)		-152,476	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: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet G

Date/Time Prepared:
9/26/2018 10:11 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	12,259,698	0	0	0	1.00
2.00	Temporary investments	44,723	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,708,364	0	0	0	4.00
5.00	Other receivable	338,496	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	244,574	0	0	0	7.00
8.00	Prepaid expenses	335,411	0	0	0	8.00
9.00	Other current assets	904,359	0	0	42,616	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,835,625	0	0	42,616	11.00
FIXED ASSETS						
12.00	Land	658,227	0	0	0	12.00
13.00	Land improvements	2,889,184	0	0	0	13.00
14.00	Accumulated depreciation	-534,693	0	0	0	14.00
15.00	Buildings	29,660,284	0	0	0	15.00
16.00	Accumulated depreciation	-5,184,281	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,758,906	0	0	0	23.00
24.00	Accumulated depreciation	-4,171,049	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,682,323	0	0	0	27.00
28.00	Accumulated depreciation	-1,546,564	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)	29,212,337	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	24	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,047,986	0	0	42,616	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	480,795	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,036,671	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	402,024	0	0	0	40.00
41.00	Deferred income	282,500	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,322,378	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,524,368	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,089,857	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)	23,089,857	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,614,225	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,433,761				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				42,616	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)	19,433,761	0	0	42,616	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,047,986	0	0	42,616	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet G-1

Date/Time Prepared:
9/26/2018 10:11 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		16,857,359		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,443,543				2.00
3.00	Total (sum of line 1 and line 2)		19,300,902		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER	132,859		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		132,859		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,433,761		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,433,761		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		175,475			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		175,475			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER		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		175,475			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER		132,859				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		132,859			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		42,616			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/26/2018 10:11 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,437,520		1,437,520	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	427,025		427,025	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,864,545		1,864,545	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)	1,864,545		1,864,545	17.00
18.00	Ancillary services	3,434,632	30,807,235	34,241,867	18.00
19.00	Outpatient services	80,367	3,152,310	3,232,677	19.00
20.00	RURAL HEALTH CLINIC	0	2,807,239	2,807,239	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	77,186	2,246,943	2,324,129	27.00
27.01	340 GROSS UP	0	-2,783	-2,783	27.01
27.02	RHC CHRONIC & TRANSITIONAL CARE	0	31,060	31,060	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,456,730	39,042,004	44,498,734	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,374,857		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)		24,374,857		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2017
To 04/30/2018

Worksheet G-3

Date/Time Prepared:
9/26/2018 10:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,498,734	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,304,192	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,194,542	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,374,857	4.00
5.00	Net income from service to patients (line 3 minus line 4)	819,685	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	118,776	6.00
7.00	Income from investments	155,285	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	52,713	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	58,012	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	5,682	17.00
18.00	Revenue from sale of medical records and abstracts	3,791	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	72	21.00
22.00	Rental of hospital space	33,679	22.00
23.00	Governmental appropriations	303,415	23.00
24.00	CONTRACT SERVICES	33,960	24.00
24.01	MISC OPERATING REVENUE	373,929	24.01
24.02	MISC NON-OPERATING REVENUE	4,675	24.02
24.03	340B DISCOUNT	786,509	24.03
25.00	Total other income (sum of lines 6-24)	1,930,498	25.00
26.00	Total (line 5 plus line 25)	2,750,183	26.00
27.00	DEMOLITION EXPENSE	306,640	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	306,640	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,443,543	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period: From 05/01/2017

Worksheet M-1

Component CCN: 14-3412

To 04/30/2018

Date/Time Prepared: 9/26/2018 10:11 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	863,431	1,676	865,107	-146,496	718,611	1.00
2.00	Physician Assistant	283,962	0	283,962	0	283,962	2.00
3.00	Nurse Practitioner	64,321	0	64,321	0	64,321	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	311,283	0	311,283	-29,500	281,783	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	20,816	20,816	-3,217	17,599	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,522,997	22,492	1,545,489	-179,213	1,366,276	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	145,251	145,251	0	145,251	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	30,678	30,678	0	30,678	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	175,929	175,929	0	175,929	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,522,997	198,421	1,721,418	-179,213	1,542,205	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	13,632	13,632	25.02
26.00	All other nonreimbursable costs	0	0	0	13,365	13,365	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	26,997	26,997	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	393,081	15,539	408,620	0	408,620	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	393,081	15,539	408,620	0	408,620	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,916,078	213,960	2,130,038	-152,216	1,977,822	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period: From 05/01/2017

Worksheet M-1

Component CCN: 14-3412

To 04/30/2018

Date/Time Prepared: 9/26/2018 10:11 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	718,611		1.00
2.00	Physician Assistant	0	283,962		2.00
3.00	Nurse Practitioner	0	64,321		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	281,783		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	17,599		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,366,276		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	145,251		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	30,678		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	175,929		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,542,205		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	13,632		25.02
26.00	All other nonreimbursable costs	0	13,365		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,997		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-792	407,828		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-792	407,828		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-792	1,977,030		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2017 To 04/30/2018	Worksheet M-2 Date/Time Prepared: 9/26/2018 10:11 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	1.86	10,614	4,200	7,812	1.00
2.00	Physician Assistant	1.71	5,861	2,100	3,591	2.00
3.00	Nurse Practitioner	0.61	1,952	2,100	1,281	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.18	18,427		12,684	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.18	18,427			8.00
9.00	Physician Services Under Agreements		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)				1,542,205	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				26,997	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,569,202	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.982796	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				407,828	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,760,462	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,168,290	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,168,290	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,130,987	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,673,192	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2017 To 04/30/2018	Worksheet M-3 Date/Time Prepared: 9/26/2018 10:11 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)			3,673,192	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			150,802	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,522,390	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,427	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)			18,427	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			191.15	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	191.15	191.15		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	4,401	2,201		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	841,251	420,721		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,261,972		16.00
16.01	Total program charges (see instructions)(from contractor's records)		976,800		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,445		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,538		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.)		911,331		16.04
16.05	Total program cost (see instructions)	0	933,869		16.05
17.00	Primary payer amounts		22		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		100,270		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		171,217		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		933,847		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		86,586		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,020,433		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,020,433		26.00
26.01	Sequestration adjustment (see instructions)		20,409		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		977,850		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)		22,174		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2017 To 04/30/2018	Worksheet M-4 Date/Time Prepared: 9/26/2018 10:11 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)		1,366,276	1,366,276	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001184	0.003490	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,618	4,768	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		37,935	18,994	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		39,553	23,762	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,542,205	1,542,205	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,130,987	2,130,987	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025647	0.015408	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		54,653	32,834	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		94,206	56,596	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		278	821	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		338.87	68.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		166	440	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		56,252	30,334	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)			150,802	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)			86,586	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2017 To 04/30/2018	Worksheet M-5 Date/Time Prepared: 9/26/2018 10:11 am
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		821,560	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		04/19/2018	156,290	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)		156,290	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		977,850	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		22,174	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,000,024	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.	06101	8.00