

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: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/23/2018 1:09 pm
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**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only  
 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
7. Contractor No.  
8.  Initial Report for this Provider CCN  
9.  Final Report for this Provider CCN

10. NPR Date:  
11. Contractor's Vendor Code: 4  
12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 8/23/2018 Time: 1:09 pm

**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 FERRELL HOSPITAL ( 14-1324 ) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	86,026	102,646	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	48,918	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		538,332		0	10.00
200.00 Total	0	134,944	640,978	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet S-2 Part I Date/Time Prepared: 8/23/2018 12:44 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1201 PINE STREET	PO Box:								1.00	
2.00	City: EL DORADO	State: IL		Zip Code: 62930		County: SALINE				2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	FERRELL HOSPITAL		141324	99914	1	02/01/2003	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	FERRELL SWINGBED SNF		14Z324	99914		02/01/2003	N	0	0	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	FERRELL HOSPITAL CLINIC		148506	99914		04/01/2009	N	0	0	15.00
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2017	03/31/2018		20.00	
21.00	Type of Control (see instructions)						2			21.00	
<u>Inpatient PPS Information</u>											
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			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.							1 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 days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0			24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0			25.00	

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		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		N			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) 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.					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
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N		0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	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	Y	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00

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		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N			109.00
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					1.00			
					2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N			111.00
					1.00			
					2.00			
					3.00			
115.00	Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				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		
		128,064		0				118.01
					1.00			
					2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				Y			122.00
					5.02			
					N			
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: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet S-2 Part I Date/Time Prepared: 8/23/2018 12:44 pm	
		1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0778		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 600 MARY STREET	PO Box:				142.00	
143.00	City: EVANSVILLE	State: IL		Zip Code: 47710		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0				168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2017		03/31/2018		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/23/2018 12:44 pm
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/23/2018 12:44 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/07/2018	Y	06/07/2018
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: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/23/2018 12:44 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			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
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	09/30/2017	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BLUE AND CO		BLUE AND CO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500		CBRI LL@BLUEANDCO.COM	43.00

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BLUE AND CO	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

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	25	9,125	50,075.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	50,075.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	50,075.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	1,405	298	2,003			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	569	0	662			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	31			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,974	298	2,696			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,974	298	2,696	0.00	134.73	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	8,122	0	25,441	0.00	39.92	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	174.65	27.00
28.00 Observation Bed Days		114	450			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: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	393	90	603	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	393	90	603		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC (CONSOLIDATED)	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2017 To 03/31/2018	Worksheet S-8 Date/Time Prepared: 8/23/2018 12:44 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification Street	1201 PINE STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EL DORADO IL		62930 2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) CLINIC	13:00	17:00	07:00	19:00
		07:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	FERRELL HOSPITAL CLINIC		148506 14.00	
14.01		EL DORADO		148507 14.01	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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	SALINE		2.00	
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1) CLINIC	19:00	07:00	19:00	07:00
		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324  
Component CCN: 14-8506

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet S-8  
Date/Time Prepared:  
8/23/2018 12:44 pm

		Friday		Saturday		RHC I		Cost	
		from	to	from	to				
11.00	Facility hours of operations (1) CLINIC	07:00	19:00	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet S-10	
				Date/Time Prepared: 8/23/2018 12:44 pm	
				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.506364	1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid			416,715	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,414,216	5.00
6.00	Medicaid charges			9,925,179	6.00
7.00	Medicaid cost (line 1 times line 6)			5,025,753	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)			2,194,822	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,194,822	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	69,635	0	69,635	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	35,261	0	35,261	21.00
22.00	Payments received from patients for amounts previously written off as charity care	591	0	591	22.00
23.00	Cost of charity care (line 21 minus line 22)	34,670	0	34,670	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)			978,116	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			521,758	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			802,704	27.01
28.00	Non-Medicare bad debt expense (see instructions)			175,412	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			369,768	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			404,438	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,599,260	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		478,512	478,512	-163,841	314,671	1.00
1.01	00101			0	47,238	47,238	1.01
2.00	00200			0	336,758	336,758	2.00
3.00	00300			0	0	0	3.00
4.00	00400	95,216	1,882,598	1,977,814	0	1,977,814	4.00
5.01	00580	545,515	211,168	756,683	53,708	810,391	5.01
5.02	00591	364,273	2,175,756	2,540,029	-38,994	2,501,035	5.02
6.00	00600	227,861	72,951	300,812	0	300,812	6.00
7.00	00700	0	222,630	222,630	0	222,630	7.00
8.00	00800	42,553	13,982	56,535	0	56,535	8.00
9.00	00900	195,805	21,213	217,018	0	217,018	9.00
10.00	01000	175,036	140,530	315,566	-111,080	204,486	10.00
11.00	01100	0	0	0	111,080	111,080	11.00
13.00	01300	196,624	15,298	211,922	0	211,922	13.00
16.00	01600	243,575	22,250	265,825	0	265,825	16.00
19.00	01900	0	254,419	254,419	0	254,419	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,259,830	72,471	1,332,301	0	1,332,301	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	419,467	260,147	679,614	-516	679,098	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	515,661	552,374	1,068,035	9,723	1,077,758	54.00
60.00	06000	437,893	466,241	904,134	5,277	909,411	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	337,574	43,143	380,717	-23,125	357,592	65.00
66.00	06600	0	583,226	583,226	-53,708	529,518	66.00
71.00	07100	0	140,725	140,725	-14,507	126,218	71.00
72.00	07200	0	0	0	39,651	39,651	72.00
73.00	07300	207,553	980,907	1,188,460	0	1,188,460	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	3,424,462	506,431	3,930,893	-59,945	3,870,948	88.00
90.00	09000	29,260	190,962	220,222	0	220,222	90.00
91.00	09100	516,491	1,311,832	1,828,323	-1,503	1,826,820	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		162,951	162,951	-158,804	4,147	113.00
118.00		9,234,649	10,782,717	20,017,366	-22,588	19,994,778	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	99,706	34,007	133,713	22,588	156,301	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		9,334,355	10,816,724	20,151,079	0	20,151,079	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-18,800	295,871	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	47,238	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,291	326,467	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	837,486	2,815,300	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	810,391	5.01
5.02	00591	OTHER ADMIN AND GENERAL	1,934,428	4,435,463	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	300,812	6.00
7.00	00700	OPERATION OF PLANT	92,171	314,801	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,535	8.00
9.00	00900	HOUSEKEEPING	0	217,018	9.00
10.00	01000	DIETARY	0	204,486	10.00
11.00	01100	CAFETERIA	-34,669	76,411	11.00
13.00	01300	NURSING ADMINISTRATION	57,466	269,388	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,767	294,592	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	254,419	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,332,301	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	679,098	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,077,758	54.00
60.00	06000	LABORATORY	0	909,411	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	357,592	65.00
66.00	06600	PHYSICAL THERAPY	0	529,518	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	126,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,111	1,310,571	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-8,325	3,862,623	88.00
90.00	09000	CLINIC	0	220,222	90.00
91.00	09100	EMERGENCY	0	1,826,820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-4,147	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,996,197	22,990,975	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156,301	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	340B	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	2,996,197	23,147,276	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CAFETERIA COSTS</b>					
1.00	CAFETERIA	11.00	61,613	49,467	1.00
	O		61,613	49,467	
<b>B - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	108,136	1.00
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	5,471	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	899	3.00
4.00	OTHER ADMIN AND GENERAL	5.02	0	29,298	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,723	5.00
6.00	LABORATORY	60.00	0	5,277	6.00
	O		0	158,804	
<b>C - PROPERTY INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	30,962	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,245	2.00
	O		0	46,207	
<b>D - PROPERTY TAXES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,250	1.00
	O		0	1,250	
<b>F - MME DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	320,614	1.00
	O		0	320,614	
<b>G - ADMIN RECRUITING</b>					
1.00	RURAL HEALTH CLINIC	88.00	0	20,835	1.00
	O		0	20,835	
<b>H - EFM BUILDING RENT</b>					
1.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	41,767	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,425	2.00
	O		0	58,192	
<b>I - IMPLANT EXPENSE</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	39,651	1.00
	TOTALS		0	39,651	
<b>J - BILLABLE OXYGEN COSTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,125	1.00
	O		0	23,125	
<b>K - PT BILLING COSTS</b>					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	53,708	1.00
	O		0	53,708	
<b>L - NON-RHC EXPENSE</b>					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	38,100	913	1.00
	TOTALS		38,100	913	
<b>M - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,019	1.00
2.00	O	0.00	0	0	2.00
	TOTALS		0	2,019	
500.00	Grand Total: Increases		99,713	774,785	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA COSTS</b>							
1.00	DIETARY	10.00	61,613	49,467	0		1.00
	O		61,613	49,467			
<b>B - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	158,804	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	O		0	158,804			
<b>C - PROPERTY INSURANCE</b>							
1.00	OTHER ADMIN AND GENERAL	5.02	0	46,207	13		1.00
2.00		0.00	0	0	13		2.00
	O		0	46,207			
<b>D - PROPERTY TAXES</b>							
1.00	OTHER ADMIN AND GENERAL	5.02	0	1,250	13		1.00
	O		0	1,250			
<b>F - MME DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	320,614	9		1.00
	O		0	320,614			
<b>G - ADMIN RECRUITING</b>							
1.00	OTHER ADMIN AND GENERAL	5.02	0	20,835	0		1.00
	O		0	20,835			
<b>H - EFM BUILDING RENT</b>							
1.00	RURAL HEALTH CLINIC	88.00	0	41,767	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,425	10		2.00
	O		0	58,192			
<b>I - IMPLANT EXPENSE</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	39,651	0		1.00
	TOTALS		0	39,651			
<b>J - BILLABLE OXYGEN COSTS</b>							
1.00	RESPIRATORY THERAPY	65.00	0	23,125	0		1.00
	O		0	23,125			
<b>K - PT BILLING COSTS</b>							
1.00	PHYSICAL THERAPY	66.00	0	53,708	0		1.00
	O		0	53,708			
<b>L - NON-RHC EXPENSE</b>							
1.00	RURAL HEALTH CLINIC	88.00	38,100	913	0		1.00
	TOTALS		38,100	913			
<b>M - MEDICAL SUPPLIES</b>							
1.00	OPERATING ROOM	50.00	0	516	0		1.00
2.00	EMERGENCY	91.00	0	1,503	0		2.00
	TOTALS		0	2,019			
500.00	Grand Total: Decreases		99,713	774,785			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A-7  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	183,412	0	0	0	0	1.00
2.00	Land Improvements	43,892	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,289,503	4,352,006	0	4,352,006	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	620,340	1,883	0	1,883	0	5.00
6.00	Movable Equipment	2,511,454	80,234	0	80,234	0	6.00
7.00	HIT designated Assets	1,524,108	65,137	0	65,137	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,172,709	4,499,260	0	4,499,260	0	8.00
9.00	Reconciling Items	-1,361,987	-814,016	0	-814,016	0	9.00
10.00	Total (line 8 minus line 9)	9,534,696	5,313,276	0	5,313,276	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	183,412	0				1.00
2.00	Land Improvements	43,892	0				2.00
3.00	Buildings and Fixtures	7,641,509	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	622,223	0				5.00
6.00	Movable Equipment	2,591,688	0				6.00
7.00	HIT designated Assets	1,589,245	0				7.00
8.00	Subtotal (sum of lines 1-7)	12,671,969	0				8.00
9.00	Reconciling Items	-2,176,003	0				9.00
10.00	Total (line 8 minus line 9)	14,847,972	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A-7  
Part II  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	478,512	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	478,512	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	478,512				1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	478,512				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A-7  
Part III  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	8,491,036	0	8,491,036	0.670064	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	4,180,933	0	4,180,933	0.329936	0	2.00
3.00	Total (sum of lines 1-2)	12,671,969	0	12,671,969	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	157,898	16,425	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	41,767	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	310,323	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	468,221	58,192	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	89,336	0	32,212	0	295,871	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	5,471	0	0	0	47,238	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	899	0	15,245	0	326,467	2.00
3.00	Total (sum of lines 1-2)	95,706	0	47,457	0	669,576	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	-18,800	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLD (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01		1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		2.00
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	-490	OTHER ADMIN AND GENERAL	5.02		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)	A	-1,823	OTHER ADMIN AND GENERAL	5.02		7.00
8.00 Television and radio service (chapter 21)	A	-7,759	OTHER ADMIN AND GENERAL	5.02		8.00
9.00 Parking lot (chapter 21)		0		0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	0				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	3,792,811				12.00
13.00 Laundry and linen service		0		0.00		13.00
14.00 Cafeteria-employees and guests	B	-34,669	CAFETERIA	11.00		14.00
15.00 Rental of quarters to employees and others	B	-8,325	RURAL HEALTH CLINIC	88.00		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	-18,485	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		0		0.00		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	A	-4,147	INTEREST EXPENSE	113.00		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLD		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01		26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00		29.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-10,291		CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00 LOBBYING DUES	A	-7,657		OTHER ADMIN AND GENERAL	5.02	0 33.00
34.00 PROVIDER TAX OFFSET	A	-446,683		OTHER ADMIN AND GENERAL	5.02	0 34.00
35.00 MARKETING/ADVERTISING	A	-60,334		OTHER ADMIN AND GENERAL	5.02	0 35.00
35.01 PHYSICIAN RECRUITMENT	A	-6,320		OTHER ADMIN AND GENERAL	5.02	0 35.01
35.02 340B OFFSET	A	-170,831		DRUGS CHARGED TO PATIENTS	73.00	0 35.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,996,197				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 14-1324  
 Period: From 04/01/2017 To 03/31/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 8/23/2018 12:44 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAI MED HOME OFFICE COSTS:</b>						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	DHS - HR/EMPLOYEE BENEFITS	837,486	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS - A&G	2,452,009	120,000	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	92,171	0	3.00
4.00	13.00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	57,466	0	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	292,942	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	DHS - MEDICAL RECORDS	47,252	0	4.02
4.03	5.02	OTHER ADMIN AND GENERAL	DHS - CASE MANAGEMENT	133,485	0	4.03
4.04	5.01	CASHIERING/ACCOUNTS RECEIVAB	DEACONESS HOSPITAL - EPIC US	44,860	44,860	4.04
4.05	5.02	OTHER ADMIN AND GENERAL	DEACONESS HOSPITAL - SUPPLIE	3,270	3,270	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	DEACONESS HOSPITAL - SUPPLIE	90	90	4.06
4.07	30.00	ADULTS & PEDIATRICS	DEACONESS HOSPITAL - SUPPLIE	2,127	2,127	4.07
4.08	50.00	OPERATING ROOM	DEACONESS HOSPITAL - SUPPLIE	635	635	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	DEACONESS HOSPITAL - SUPPLIE	45	45	4.09
4.10	88.00	RURAL HEALTH CLINIC	DEACONESS HOSPITAL - SUPPLIE	745	745	4.10
4.11	194.00	MARKETING	DEACONESS HOSPITAL - SUPPLIE	3,251	3,251	4.11
4.12	50.00	OPERATING ROOM	DRHS IL - PAIN MGT COVERAGE	97,618	97,618	4.12
4.13	91.00	EMERGENCY	DRHS IL - ER COVERAGE	749,250	749,250	4.13
4.14	5.02	OTHER ADMIN AND GENERAL	DRHS IL - C SUITE SALARY/BEN	393,410	393,410	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,208,112	1,415,301	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

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

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

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

6.00	B	0.00	DEACONESS HLTH	0.00	6.00
7.00	B	0.00	DEACONESS HOSP	0.00	7.00
8.00	B	0.00	DRHS IL	0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A-8-1

Date/Time Prepared:  
8/23/2018 12:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	837,486	0		1.00
2.00	2,332,009	0		2.00
3.00	92,171	0		3.00
4.00	57,466	0		4.00
4.01	292,942	0		4.01
4.02	47,252	0		4.02
4.03	133,485	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	3,792,811			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	PROF SVS CO		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet A-8-2

Date/Time Prepared:  
8/23/2018 12:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,433,646	0	1,433,646	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,433,646	0	1,433,646	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm	
		Physical Therapy				Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	124.00	1,878.00	1,861.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	81.09	81.09	60.82	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)	40.55	40.55	30.41			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					10,055	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					152,287	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					113,186	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					275,528	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)					275,528	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)					275,528	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm		
						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		
<b>PART V - OVERTIME COMPUTATION</b>								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
<b>CALCULATION OF LIMIT</b>								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>								
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.09	60.82	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>								
57.00	Salary equivalency amount (from line 23)					275,528	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					894	61.00	
62.00	Supplies (see instructions)					5,463	62.00	
63.00	Total allowance (sum of lines 57-62)					281,885	63.00	
64.00	Total cost of outside supplier services (from your records)					258,278	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00	
<b>LINE 33 CALCULATION</b>								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02	
<b>LINE 34 CALCULATION</b>								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	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					0	101.02	
<b>LINE 35 CALCULATION</b>								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01	
102.02	Line 35 = sum of lines 31 and 32					0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm	
				Occupational Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	48.00	1,048.00	388.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	76.85	76.85	57.64	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.43	38.43	28.82			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					3,689	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					80,539	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					22,364	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					106,592	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)					106,592	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)					106,592	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.85	57.64	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					106,592	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					106,592	63.00
64.00	Total cost of outside supplier services (from your records)					99,194	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	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					0	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm	
				Speech Pathology		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	4.00	118.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	73.85	73.85	55.39	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.93	36.93	27.70			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					295	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,714	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)					9,009	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)					9,009	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.84	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,595	22.00
23.00	Total salary equivalency (see instructions)					57,595	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/23/2018 12:44 pm	
						Speech Pathology	Cost
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0 46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.85	55.39	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					57,595	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					57,595	63.00
64.00	Total cost of outside supplier services (from your records)					8,151	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0 100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0 101.00
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						0 101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0 102.01
102.02	Line 35 = sum of lines 31 and 32						0 102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - EFM BLD	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	295,871	295,871			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	47,238	0	47,238		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	326,467			326,467	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,815,300	1,525	0	1,585	2,818,410
5.01 00580	CASHIERING/ACCOUNTS RECEIVABLE	810,391	4,010	695	4,446	303,634
5.02 00591	OTHER ADMIN AND GENERAL	4,435,463	50,142	12,078	56,962	134,676
6.00 00600	MAINTENANCE & REPAIRS	300,812	6,777	0	7,043	85,377
7.00 00700	OPERATION OF PLANT	314,801	56,345	1,402	59,122	0
8.00 00800	LAUNDRY & LINEN SERVICE	56,535	4,993	0	5,189	32,812
9.00 00900	HOUSEKEEPING	217,018	1,671	317	1,864	116,720
10.00 01000	DIETARY	204,486	9,558	0	9,934	71,174
11.00 01100	CAFETERIA	76,411	0	2,474	993	38,689
13.00 01300	NURSING ADMINISTRATION	269,388	508	0	528	49,953
16.00 01600	MEDICAL RECORDS & LIBRARY	294,592	11,727	0	12,189	127,494
19.00 01900	NONPHYSICIAN ANESTHETISTS	254,419	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,332,301	41,850	0	43,497	400,601
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	679,098	15,567	0	16,180	145,614
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,077,758	13,153	0	13,671	155,572
60.00 06000	LABORATORY	909,411	5,963	2,681	7,273	187,894
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	357,592	5,953	0	6,187	116,393
66.00 06600	PHYSICAL THERAPY	529,518	5,770	0	5,997	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	126,218	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	39,651	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,310,571	3,233	0	3,360	50,932
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	3,862,623	39,455	27,591	52,081	651,670
90.00 09000	CLINIC	220,222	9,840	0	10,227	16,488
91.00 09100	EMERGENCY	1,826,820	7,831	0	8,139	117,046
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	22,990,975	295,871	47,238	326,467	2,802,739
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	156,301	0	0	0	15,671
194.00 07950	MARKETING	0	0	0	0	0
194.01 07951	340B	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	23,147,276	295,871	47,238	326,467	2,818,410

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

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Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.01	5A.01	5.02	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,123,176				5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	4,689,321	4,689,321		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	400,009	101,624	501,633	6.00
7.00	00700	OPERATION OF PLANT	0	431,670	109,667	115,658	656,995
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,529	25,286	10,152	17,280
9.00	00900	HOUSEKEEPING	0	337,590	85,766	3,645	6,205
10.00	01000	DIETARY	0	295,152	74,985	19,433	33,078
11.00	01100	CAFETERIA	0	118,567	30,122	1,942	3,306
13.00	01300	NURSING ADMINISTRATION	0	320,377	81,393	1,033	1,759
16.00	01600	MEDICAL RECORDS & LIBRARY	0	446,002	113,309	23,844	40,586
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	254,419	64,636	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	91,973	1,910,222	485,300	85,089	144,835
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	81,888	938,347	238,391	31,651	53,876
53.00	05300	ANESTHESIOLOGY	26,700	26,700	6,783	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,940	1,515,094	384,916	26,743	45,521
60.00	06000	LABORATORY	202,634	1,315,856	334,298	14,228	24,218
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	34,832	520,957	132,351	12,104	20,602
66.00	06600	PHYSICAL THERAPY	57,012	598,297	152,000	11,730	19,967
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,991	165,209	41,972	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,521	42,172	10,714	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	105,173	1,473,269	374,290	6,573	11,189
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	125,540	4,758,960	1,209,036	101,880	173,417
90.00	09000	CLINIC	11,054	267,831	68,044	20,007	34,055
91.00	09100	EMERGENCY	89,918	2,049,754	520,748	15,921	27,101
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,123,176	22,975,304	4,645,631	501,633	656,995
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	171,972	43,690	0	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,123,176	23,147,276	4,689,321	501,633	656,995

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01	
5.02	00591	OTHER ADMIN AND GENERAL					5.02	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	152,247				8.00	
9.00	00900	HOUSEKEEPING	35,646	468,852			9.00	
10.00	01000	DIETARY	1,058	24,480	448,186		10.00	
11.00	01100	CAFETERIA	0	2,447	0	156,384	11.00	
13.00	01300	NURSING ADMINISTRATION	0	1,302	0	3,865	409,729	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,037	0	9,877	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	77,057	107,191	448,186	31,019	210,572	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	19,903	39,873	0	11,268	76,492	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,419	33,689	0	12,052	0	54.00
60.00	06000	LABORATORY	34	17,923	0	14,549	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,248	0	9,011	61,172	65.00
66.00	06600	PHYSICAL THERAPY	3,554	14,777	0	0	0	66.00
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	8,281	0	3,942	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	412	128,343	0	50,461	0	88.00
90.00	09000	CLINIC	0	25,204	0	1,282	0	90.00
91.00	09100	EMERGENCY	3,164	20,057	0	9,058	61,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,247	468,852	448,186	156,384	409,729	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
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)	152,247	468,852	448,186	156,384	409,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	663,655					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	319,055				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	54,343	0	3,553,814	0	3,553,814	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	48,385	0	1,458,186	0	1,458,186	50.00
53.00	05300	ANESTHESIOLOGY	15,776	319,055	368,314	0	368,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,647	0	2,180,081	0	2,180,081	54.00
60.00	06000	LABORATORY	119,729	0	1,840,835	0	1,840,835	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,581	0	792,026	0	792,026	65.00
66.00	06600	PHYSICAL THERAPY	33,686	0	834,011	0	834,011	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,038	0	230,219	0	230,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,490	0	54,376	0	54,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,143	0	1,939,687	0	1,939,687	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	74,177	0	6,496,686	0	6,496,686	88.00
90.00	09000	CLINIC	6,531	0	422,954	0	422,954	90.00
91.00	09100	EMERGENCY	53,129	0	2,760,425	0	2,760,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	663,655	319,055	22,931,614	0	22,931,614	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	215,662	0	215,662	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	663,655	319,055	23,147,276	0	23,147,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B  
Part II  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	BLDG & FIXT - EFM BLD	MVBLE EQUIP		
		0	1.00	1.01		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,525	0	1,585	4.00
5.01 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	4,010	695	4,446	5.01
5.02 00591	OTHER ADMIN AND GENERAL	0	50,142	12,078	56,962	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	6,777	0	7,043	6.00
7.00 00700	OPERATION OF PLANT	0	56,345	1,402	59,122	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,993	0	5,189	8.00
9.00 00900	HOUSEKEEPING	0	1,671	317	1,864	9.00
10.00 01000	DIETARY	0	9,558	0	9,934	10.00
11.00 01100	CAFETERIA	0	0	2,474	993	11.00
13.00 01300	NURSING ADMINISTRATION	0	508	0	528	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,727	0	12,189	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	41,850	0	43,497	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	15,567	0	16,180	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,723	13,153	0	13,671	54.00
60.00 06000	LABORATORY	5,277	5,963	2,681	7,273	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	5,953	0	6,187	65.00
66.00 06600	PHYSICAL THERAPY	0	5,770	0	5,997	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,233	0	3,360	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	39,455	27,591	52,081	88.00
90.00 09000	CLINIC	0	9,840	0	10,227	90.00
91.00 09100	EMERGENCY	0	7,831	0	8,139	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15,000	295,871	47,238	326,467	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	0	0	0	0	194.00
194.01 07951	340B	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	15,000	295,871	47,238	326,467	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet B Part II Date/Time Prepared: 8/23/2018 12:44 pm		
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	CASHIERING/AC COUNTS RECEIVABLE 5.01	OTHER ADMIN AND GENERAL 5.02	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,110				4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	335	9,486			5.01
5.02	00591	OTHER ADMIN AND GENERAL	149	0	119,331		5.02
6.00	00600	MAINTENANCE & REPAIRS	94	0	2,586	16,500	6.00
7.00	00700	OPERATION OF PLANT	0	0	2,791	3,804	123,464
8.00	00800	LAUNDRY & LINEN SERVICE	36	0	643	334	3,247
9.00	00900	HOUSEKEEPING	129	0	2,183	120	1,166
10.00	01000	DIETARY	79	0	1,908	639	6,216
11.00	01100	CAFETERIA	43	0	767	64	621
13.00	01300	NURSING ADMINISTRATION	55	0	2,071	34	331
16.00	01600	MEDICAL RECORDS & LIBRARY	141	0	2,883	784	7,627
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,645	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	442	775	12,350	2,799	27,218
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	161	690	6,066	1,041	10,124
53.00	05300	ANESTHESIOLOGY	0	225	173	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	172	2,169	9,795	880	8,554
60.00	06000	LABORATORY	207	1,708	8,507	468	4,551
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	128	294	3,368	398	3,872
66.00	06600	PHYSICAL THERAPY	0	480	3,868	386	3,752
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	329	1,068	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21	273	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	56	886	9,525	216	2,103
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	719	1,058	30,765	3,351	32,589
90.00	09000	CLINIC	18	93	1,732	658	6,400
91.00	09100	EMERGENCY	129	758	13,252	524	5,093
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,093	9,486	118,219	16,500	123,464
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17	0	1,112	0	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	3,110	9,486	119,331	16,500	123,464

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet B Part II Date/Time Prepared: 8/23/2018 12:44 pm				
Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01	
5.02	00591	OTHER ADMIN AND GENERAL					5.02	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	14,442				8.00	
9.00	00900	HOUSEKEEPING	3,381	10,831			9.00	
10.00	01000	DIETARY	100	566	29,000		10.00	
11.00	01100	CAFETERIA	0	57	0	5,019	11.00	
13.00	01300	NURSING ADMINISTRATION	0	30	0	124	3,681	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	694	0	317	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	7,311	2,476	29,000	995	1,892	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,888	921	0	362	687	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,083	778	0	387	0	54.00
60.00	06000	LABORATORY	3	414	0	467	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	352	0	289	550	65.00
66.00	06600	PHYSICAL THERAPY	337	341	0	0	0	66.00
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	191	0	127	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	39	2,966	0	1,619	0	88.00
90.00	09000	CLINIC	0	582	0	41	0	90.00
91.00	09100	EMERGENCY	300	463	0	291	552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,442	10,831	29,000	5,019	3,681	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
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)	14,442	10,831	29,000	5,019	3,681	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet B Part II Date/Time Prepared: 8/23/2018 12:44 pm
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Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	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	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,362				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,645			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,978	173,583	0	173,583	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,651	56,338	0	56,338	50.00
53.00	05300	ANESTHESIOLOGY	864	1,262	0	1,262	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,251	68,616	0	68,616	54.00
60.00	06000	LABORATORY	6,561	44,080	0	44,080	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,128	22,519	0	22,519	65.00
66.00	06600	PHYSICAL THERAPY	1,846	22,777	0	22,777	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,262	2,659	0	2,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82	376	0	376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,405	23,102	0	23,102	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,065	196,298	0	196,298	88.00
90.00	09000	CLINIC	358	29,949	0	29,949	90.00
91.00	09100	EMERGENCY	2,911	40,243	0	40,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,362	681,802	0	681,802	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,129	0	1,129	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	194.01
200.00		Cross Foot Adjustments		1,645	0	1,645	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,362	1,645	684,576	684,576	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B-1

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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (FTE'S)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - EFM BLD (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	62,871				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	3,876			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			66,747		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	324	0	324	17,265	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	852	57	909	1,860	45,286,848
5.02	00591	OTHER ADMIN AND GENERAL	10,655	991	11,646	825	0
6.00	00600	MAINTENANCE & REPAIRS	1,440	0	1,440	523	0
7.00	00700	OPERATION OF PLANT	11,973	115	12,088	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,061	0	1,061	201	0
9.00	00900	HOUSEKEEPING	355	26	381	715	0
10.00	01000	DIETARY	2,031	0	2,031	436	0
11.00	01100	CAFETERIA	0	203	203	237	0
13.00	01300	NURSING ADMINISTRATION	108	0	108	306	0
16.00	01600	MEDICAL RECORDS & LIBRARY	2,492	0	2,492	781	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,893	0	8,893	2,454	3,708,428
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,308	0	3,308	892	3,301,815
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,076,578
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	0	2,795	953	10,278,757
60.00	06000	LABORATORY	1,267	220	1,487	1,151	8,170,389
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,265	0	1,265	713	1,404,441
66.00	06600	PHYSICAL THERAPY	1,226	0	1,226	0	2,298,778
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,572,141
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	101,669
73.00	07300	DRUGS CHARGED TO PATIENTS	687	0	687	312	4,240,695
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	8,384	2,264	10,648	3,992	5,061,895
90.00	09000	CLINIC	2,091	0	2,091	101	445,700
91.00	09100	EMERGENCY	1,664	0	1,664	717	3,625,562
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,871	3,876	66,747	17,169	45,286,848
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	96	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	295,871	47,238	326,467	2,818,410	1,123,176
203.00		Unit cost multiplier (Wkst. B, Part I)	4.706001	12.187307	4.891111	163.244136	0.024801
204.00		Cost to be allocated (per Wkst. B, Part II)				3,110	9,486
205.00		Unit cost multiplier (Wkst. B, Part II)				0.180133	0.000209
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A.02	5.02	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00580						5.01
5.02	00591	-4,689,321	18,457,955				5.02
6.00	00600	0	400,009	52,428			6.00
7.00	00700	0	431,670	12,088	40,340		7.00
8.00	00800	0	99,529	1,061	1,061	97,813	8.00
9.00	00900	0	337,590	381	381	22,901	9.00
10.00	01000	0	295,152	2,031	2,031	680	10.00
11.00	01100	0	118,567	203	203	0	11.00
13.00	01300	0	320,377	108	108	0	13.00
16.00	01600	0	446,002	2,492	2,492	0	16.00
19.00	01900	0	254,419	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	1,910,222	8,893	8,893	49,506	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	938,347	3,308	3,308	12,787	50.00
53.00	05300	0	26,700	0	0	0	53.00
54.00	05400	0	1,515,094	2,795	2,795	7,336	54.00
60.00	06000	0	1,315,856	1,487	1,487	22	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	520,957	1,265	1,265	0	65.00
66.00	06600	0	598,297	1,226	1,226	2,283	66.00
71.00	07100	0	165,209	0	0	0	71.00
72.00	07200	0	42,172	0	0	0	72.00
73.00	07300	0	1,473,269	687	687	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	4,758,960	10,648	10,648	265	88.00
90.00	09000	0	267,831	2,091	2,091	0	90.00
91.00	09100	0	2,049,754	1,664	1,664	2,033	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		-4,689,321	18,285,983	52,428	40,340	97,813	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	171,972	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00			4,689,321	501,633	656,995	152,247	202.00
203.00			0.254054	9.568036	16.286440	1.556511	203.00
204.00			119,331	16,500	123,464	14,442	204.00
205.00			0.006465	0.314717	3.060585	0.147649	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00580						5.01
5.02	00591						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	38,898					9.00
10.00	01000	2,031	2,003				10.00
11.00	01100	203	0	257,355			11.00
13.00	01300	108	0	6,360	99,325		13.00
16.00	01600	2,492	0	16,255	0	45,286,848	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	8,893	2,003	51,046	51,046	3,708,428	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,308	0	18,544	18,543	3,301,815	50.00
53.00	05300	0	0	0	0	1,076,578	53.00
54.00	05400	2,795	0	19,833	0	10,278,757	54.00
60.00	06000	1,487	0	23,943	0	8,170,389	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,265	0	14,829	14,829	1,404,441	65.00
66.00	06600	1,226	0	0	0	2,298,778	66.00
71.00	07100	0	0	0	0	1,572,141	71.00
72.00	07200	0	0	0	0	101,669	72.00
73.00	07300	687	0	6,487	0	4,240,695	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	10,648	0	83,042	0	5,061,895	88.00
90.00	09000	2,091	0	2,109	0	445,700	90.00
91.00	09100	1,664	0	14,907	14,907	3,625,562	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		38,898	2,003	257,355	99,325	45,286,848	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		468,852	448,186	156,384	409,729	663,655	202.00
203.00		12.053370	223.757364	0.607659	4.125135	0.014654	203.00
204.00		10,831	29,000	5,019	3,681	36,362	204.00
205.00		0.278446	14.478283	0.019502	0.037060	0.000803	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.01
5.02	00591	OTHER ADMIN AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	340B	194.01
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
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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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	3,553,814		3,553,814	0	0 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	1,458,186		1,458,186	0	0 50.00
53.00	05300 ANESTHESIOLOGY	368,314		368,314	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,180,081		2,180,081	0	0 54.00
60.00	06000 LABORATORY	1,840,835		1,840,835	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	792,026	0	792,026	0	0 65.00
66.00	06600 PHYSICAL THERAPY	834,011	0	834,011	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	230,219		230,219	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	54,376		54,376	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,939,687		1,939,687	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	6,496,686		6,496,686	0	0 88.00
90.00	09000 CLINIC	422,954		422,954	0	0 90.00
91.00	09100 EMERGENCY	2,760,425		2,760,425	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	512,699		512,699	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	23,444,313	0	23,444,313	0	0 200.00
201.00	Less Observation Beds	512,699		512,699		0 201.00
202.00	Total (see instructions)	22,931,614	0	22,931,614	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,064,698		3,064,698		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	186,392	3,115,423	3,301,815	0.441632	50.00
53.00	05300	ANESTHESIOLOGY	143,808	932,770	1,076,578	0.342115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,985	9,641,772	10,278,757	0.212096	54.00
60.00	06000	LABORATORY	985,911	7,184,478	8,170,389	0.225306	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	791,067	613,374	1,404,441	0.563944	65.00
66.00	06600	PHYSICAL THERAPY	651,424	1,647,354	2,298,778	0.362806	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	714,117	858,024	1,572,141	0.146437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,314	81,355	101,669	0.534834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,069	2,514,626	4,240,695	0.457398	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	5,061,895	5,061,895		88.00
90.00	09000	CLINIC	0	445,700	445,700	0.948966	90.00
91.00	09100	EMERGENCY	122,813	3,502,749	3,625,562	0.761379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	126,888	516,842	643,730	0.796450	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,170,486	36,116,362	45,286,848		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,170,486	36,116,362	45,286,848		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,553,814	0	3,553,814	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,458,186	0	1,458,186	50.00
53.00	05300 ANESTHESIOLOGY		368,314	0	368,314	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,180,081	0	2,180,081	54.00
60.00	06000 LABORATORY		1,840,835	0	1,840,835	60.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	792,026	0	792,026	65.00
66.00	06600 PHYSICAL THERAPY	0	834,011	0	834,011	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		230,219	0	230,219	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		54,376	0	54,376	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,939,687	0	1,939,687	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		6,496,686	0	6,496,686	88.00
90.00	09000 CLINIC		422,954	0	422,954	90.00
91.00	09100 EMERGENCY		2,760,425	0	2,760,425	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		512,699	0	512,699	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		23,444,313	0	23,444,313	200.00
201.00	Less Observation Beds		512,699		512,699	201.00
202.00	Total (see instructions)		22,931,614	0	22,931,614	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet C  
Part I  
Date/Time Prepared:  
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		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,064,698		3,064,698		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	186,392	3,115,423	3,301,815	0.441632	50.00
53.00	05300	ANESTHESIOLOGY	143,808	932,770	1,076,578	0.342115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,985	9,641,772	10,278,757	0.212096	54.00
60.00	06000	LABORATORY	985,911	7,184,478	8,170,389	0.225306	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	791,067	613,374	1,404,441	0.563944	65.00
66.00	06600	PHYSICAL THERAPY	651,424	1,647,354	2,298,778	0.362806	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	714,117	858,024	1,572,141	0.146437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,314	81,355	101,669	0.534834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,726,069	2,514,626	4,240,695	0.457398	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	5,061,895	5,061,895	1.283449	88.00
90.00	09000	CLINIC	0	445,700	445,700	0.948966	90.00
91.00	09100	EMERGENCY	122,813	3,502,749	3,625,562	0.761379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	126,888	516,842	643,730	0.796450	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,170,486	36,116,362	45,286,848		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,170,486	36,116,362	45,286,848		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet C Part I Date/Time Prepared: 8/23/2018 12:44 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet D Part II Date/Time Prepared: 8/23/2018 12:44 pm	
Title XVIII			Hospital		Cost			
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	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	56,338	3,301,815	0.017063	63,723	1,087	50.00
53.00	05300	ANESTHESIOLOGY	1,262	1,076,578	0.001172	13,229	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,616	10,278,757	0.006676	311,110	2,077	54.00
60.00	06000	LABORATORY	44,080	8,170,389	0.005395	592,279	3,195	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	22,519	1,404,441	0.016034	345,342	5,537	65.00
66.00	06600	PHYSICAL THERAPY	22,777	2,298,778	0.009908	210,508	2,086	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,659	1,572,141	0.001691	471,077	797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	376	101,669	0.003698	19,350	72	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,102	4,240,695	0.005448	855,419	4,660	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	196,298	5,061,895	0.038780	0	0	88.00
90.00	09000	CLINIC	29,949	445,700	0.067195	0	0	90.00
91.00	09100	EMERGENCY	40,243	3,625,562	0.011100	10,236	114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	25,042	643,730	0.038901	33	1	92.00
200.00		Total (lines 50 through 199)	533,261	42,222,150		2,892,306	19,642	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/23/2018 12:44 pm
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Cost Center Description	Title XVIII					Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost		
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	319,055	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	319,055	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/23/2018 12:44 pm
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Cost Center Description	Title XVIII			Hospital	Cost	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
	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)	8.00			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	3,301,815	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	319,055	0	1,076,578	0.296360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,278,757	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,170,389	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,404,441	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,298,778	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,572,141	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	101,669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,240,695	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,061,895	0.000000	88.00
90.00	09000	CLINIC	0	0	0	445,700	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,625,562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	643,730	0.000000	92.00
200.00		Total (lines 50 through 199)	0	319,055	0	42,222,150		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part IV Date/Time Prepared: 8/23/2018 12:44 pm
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Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Hospital		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				Outpatient Program Charges	Outpatient Program Pass-Through Costs		
	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.000000	63,723	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.000000	13,229	3,921	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	311,110	0	0	0	0	54.00
60.00 06000 LABORATORY	0.000000	592,279	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	345,342	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	210,508	0	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	471,077	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	19,350	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	855,419	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
90.00 09000 CLINIC	0.000000	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	10,236	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	33	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		2,892,306	3,921	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
	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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.441632	0	1,219,725	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.342115	0	404,508	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212096	0	3,635,817	0	0	54.00
60.00	06000	LABORATORY	0.225306	0	3,564,168	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.563944	0	415,364	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.362806	0	682,559	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	0	476,439	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.534834	0	56,063	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.457398	0	1,445,485	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.948966	0	9,100	0	0	90.00
91.00	09100	EMERGENCY	0.761379	0	1,221,845	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796450	0	321,347	0	0	92.00
200.00		Subtotal (see instructions)		0	13,452,420	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	13,452,420	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	538,670	0	50.00
53.00	05300	ANESTHESIOLOGY	138,388	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	771,142	0	54.00
60.00	06000	LABORATORY	803,028	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	234,242	0	65.00
66.00	06600	PHYSICAL THERAPY	247,637	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,768	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,984	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	661,162	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	8,636	0	90.00
91.00	09100	EMERGENCY	930,287	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	255,937	0	92.00
200.00		Subtotal (see instructions)	4,688,881	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,688,881	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.441632	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.342115	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212096	0	0	0	54.00
60.00	06000 LABORATORY	0.225306	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.563944	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.362806	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534834	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.457398	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	0.948966	0	0	0	90.00
91.00	09100 EMERGENCY	0.761379	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.796450	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
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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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.441632	0	915,403	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.342115	0	81,547	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212096	0	3,027,492	0	0	54.00
60.00	06000	LABORATORY	0.225306	0	954,956	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.563944	0	189,158	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.362806	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	0	169,553	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.534834	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.457398	0	524,516	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1.283449				0	88.00
90.00	09000	CLINIC	0.948966	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.761379	0	1,249,590	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.796450	0	163,149	0	0	92.00
200.00		Subtotal (see instructions)		0	7,275,364	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	7,275,364	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Prepared: 8/23/2018 12:44 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	404,271	0	50.00
53.00	05300	ANESTHESIOLOGY	27,898	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	642,119	0	54.00
60.00	06000	LABORATORY	215,157	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	106,675	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,829	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,913	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	951,412	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,940	0	92.00
200.00		Subtotal (see instructions)	2,742,214	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,742,214	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/23/2018 12:44 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,453	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)		2,003	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		662	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,405	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		569	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,553,814	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		4,818	25.00
26.00	Total swing-bed cost (see instructions)		759,048	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,794,766	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,794,766	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,139.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,600,745	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)		1,600,745	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/23/2018 12:44 pm
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					981,643 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,582,388 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 anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					648,273 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					648,273 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)					450 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,139.33 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					512,699 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet D-1 Date/Time Prepared: 8/23/2018 12:44 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	173,583	3,553,814	0.048844	512,699	25,042	90.00
91.00	Nursing School cost	0	3,553,814	0.000000	512,699	0	91.00
92.00	Allied health cost	0	3,553,814	0.000000	512,699	0	92.00
93.00	All other Medical Education	0	3,553,814	0.000000	512,699	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 8/23/2018 12:44 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,453	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)		2,003	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		662	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		298	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,553,814	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		4,818	25.00
26.00	Total swing-bed cost (see instructions)		759,048	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,794,766	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,794,766	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,139.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		339,517	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)		339,517	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Prepared: 8/23/2018 12:44 pm
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					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)					348,854 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					688,371 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					450 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,139.33 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					512,699 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet D-1 Date/Time Prepared: 8/23/2018 12:44 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	173,583	3,553,814	0.048844	512,699	25,042	90.00
91.00	Nursing School cost	0	3,553,814	0.000000	512,699	0	91.00
92.00	Allied health cost	0	3,553,814	0.000000	512,699	0	92.00
93.00	All other Medical Education	0	3,553,814	0.000000	512,699	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-3 Date/Time Prepared: 8/23/2018 12:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,917,825		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.441632	63,723	28,142	50.00
53.00	05300 ANESTHESIOLOGY	0.342115	13,229	4,526	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212096	311,110	65,985	54.00
60.00	06000 LABORATORY	0.225306	592,279	133,444	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.563944	345,342	194,754	65.00
66.00	06600 PHYSICAL THERAPY	0.362806	210,508	76,374	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	471,077	68,983	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534834	19,350	10,349	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.457398	855,419	391,267	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.948966	0	0	90.00
91.00	09100 EMERGENCY	0.761379	10,236	7,793	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.796450	33	26	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,892,306	981,643	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,892,306		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-3 Date/Time Prepared: 8/23/2018 12:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.441632	5,019	2,217	50.00
53.00	05300 ANESTHESIOLOGY	0.342115	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212096	28,564	6,058	54.00
60.00	06000 LABORATORY	0.225306	76,785	17,300	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.563944	91,757	51,746	65.00
66.00	06600 PHYSICAL THERAPY	0.362806	332,835	120,755	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	149,438	21,883	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534834	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.457398	235,730	107,822	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.948966	0	0	90.00
91.00	09100 EMERGENCY	0.761379	451	343	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.796450	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		920,579	328,124	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)		920,579		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-3 Date/Time Prepared: 8/23/2018 12:44 pm	
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		406,770		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.441632	117,182	51,751	50.00
53.00	05300 ANESTHESIOLOGY	0.342115	19,334	6,614	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212096	166,945	35,408	54.00
60.00	06000 LABORATORY	0.225306	211,685	47,694	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.563944	61,109	34,462	65.00
66.00	06600 PHYSICAL THERAPY	0.362806	11,797	4,280	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437	83,776	12,268	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534834	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.457398	276,343	126,399	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.283449	0	0	88.00
90.00	09000 CLINIC	0.948966	0	0	90.00
91.00	09100 EMERGENCY	0.761379	39,373	29,978	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.796450	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		987,544	348,854	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)		987,544		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet D-3 Date/Time Prepared: 8/23/2018 12:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.441632		0	50.00
53.00	05300 ANESTHESIOLOGY	0.342115		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212096		0	54.00
60.00	06000 LABORATORY	0.225306		0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		0	64.00
65.00	06500 RESPIRATORY THERAPY	0.563944		0	65.00
66.00	06600 PHYSICAL THERAPY	0.362806		0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.146437		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.534834		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.457398		0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.283449		0	88.00
90.00	09000 CLINIC	0.948966		0	90.00
91.00	09100 EMERGENCY	0.761379		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.796450		0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			0	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)			0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/23/2018 12:44 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		4,688,881	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,688,881	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		4,735,770	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,027,495	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,708,275	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,708,275	30.00
31.00	Primary payer payments		683	31.00
32.00	Subtotal (line 30 minus line 31)		2,707,592	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		693,584	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		450,830	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		594,008	36.00
37.00	Subtotal (see instructions)		3,158,422	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)		3,158,422	40.00
40.01	Sequestration adjustment (see instructions)		63,168	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,992,608	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		102,646	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1324		Period: From 04/01/2017 To 03/31/2018		Worksheet E-1 Part I Date/Time Prepared: 8/23/2018 12:44 pm	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,003,616		2,745,177	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	06/22/2017	35,374	06/22/2017	93,102		3.01
3.02		03/22/2018	157,775	03/22/2018	154,329		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)		193,149		247,431		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)		2,196,765		2,992,608		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		86,026		102,646		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,282,791		3,095,254		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1324

Period: From 04/01/2017

Worksheet E-1

Component CCN: 14-Z324

To 03/31/2018

Part I  
Date/Time Prepared:  
8/23/2018 12:44 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		823,130		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	03/22/2018	36,868		0	3.01
3.02		06/22/2017	39,310		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)		76,178		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)		899,308		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		48,918		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		948,226		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet E-1 Part II Date/Time Prepared: 8/23/2018 12:44 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet E-2 Date/Time Prepared: 8/23/2018 12:44 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	654,756	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)	331,405	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	569	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)	986,161	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	986,161	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)	986,161	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	18,583	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)	967,578	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)	967,578	0	19.00
19.01	Sequestration adjustment (see instructions)	19,352	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	899,308	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)	48,918	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
<b>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement</b>				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2017 To 03/31/2018	Worksheet E-2 Date/Time Prepared: 8/23/2018 12:44 pm
		Title XIX	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
<b>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement</b>				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet E-3 Part V Date/Time Prepared: 8/23/2018 12:44 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			2,582,388 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)			2,582,388 4.00
5.00	Primary payer payments			184 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,608,028 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,608,028 19.00
20.00	Deductibles (exclude professional component)			346,568 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,261,460 22.00
23.00	Coinurance			3,009 23.00
24.00	Subtotal (line 22 minus line 23)			2,258,451 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			109,120 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			70,928 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			93,246 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,329,379 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)			2,329,379 30.00
30.01	Sequestration adjustment (see instructions)			46,588 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			2,196,765 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)			86,026 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 8/23/2018 12:44 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		688,371		1.00
2.00	Medical and other services			2,742,214	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		695,255	2,769,636	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		695,255	2,769,636	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		987,544	7,275,364	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		987,544	7,275,364	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		987,544	7,275,364	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		292,289	4,505,728	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		695,255	2,769,636	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		695,255	2,769,636	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		695,255	2,769,636	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		695,255	2,769,636	36.00
37.00	ZERO OUT MEDICAID SETTLEMENT		-695,255	-2,769,636	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet G  
Date/Time Prepared:  
8/23/2018 12:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	810,214	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,093,107	0	0	0	4.00
5.00	Other receivable	402,272	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,880,122	0	0	0	6.00
7.00	Inventory	225,708	0	0	0	7.00
8.00	Prepaid expenses	409,738	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,060,917	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	183,412	0	0	0	12.00
13.00	Land improvements	43,892	0	0	0	13.00
14.00	Accumulated depreciation	-41,962	0	0	0	14.00
15.00	Buildings	6,087,729	0	0	0	15.00
16.00	Accumulated depreciation	-1,498,025	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	4,180,933	0	0	0	25.00
26.00	Accumulated depreciation	-4,121,264	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,834,715	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,895,632	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	754,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	142,395	0	0	0	38.00
39.00	Payroll taxes payable	698,035	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,735,406	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	68	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,330,701	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	388,414	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)	388,414	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,719,115	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,176,517				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,176,517	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,895,632	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet G-1

Date/Time Prepared:  
8/23/2018 12:44 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3,507,377		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		669,140				2.00
3.00	Total (sum of line 1 and line 2)		4,176,517		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,176,517		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,176,517		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1324

Period:  
From 04/01/2017  
To 03/31/2018

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/23/2018 12:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	3,235,236		3,235,236	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	3,235,236		3,235,236	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
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)	3,235,236		3,235,236	17.00
18.00	Ancillary services	5,725,277	31,436,249	37,161,526	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	5,061,895	5,061,895	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,960,513	36,498,144	45,458,657	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,151,079		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)		20,151,079		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1324	Period: From 04/01/2017 To 03/31/2018	Worksheet G-3 Date/Time Prepared: 8/23/2018 12:44 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,458,657	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,766,140	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,692,517	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,151,079	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-458,562	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	994,130	6.00
7.00	Income from investments	71,603	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	490	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	34,669	14.00
15.00	Revenue from rental of living quarters	8,325	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	18,485	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	1,127,702	25.00
26.00	Total (line 5 plus line 25)	669,140	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	669,140	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period: From 04/01/2017

Worksheet M-1

Component CCN: 14-8506

To 03/31/2018

Date/Time Prepared: 8/23/2018 12:44 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	1,677,435	0	1,677,435	0	1,677,435	1.00
2.00	Physician Assistant	618,580	0	618,580	-38,100	580,480	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	8,193	0	8,193	0	8,193	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,304,208	0	2,304,208	-38,100	2,266,108	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	219	219	0	219	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	219	219	0	219	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,304,208	219	2,304,427	-38,100	2,266,327	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	48,657	48,657	-41,767	6,890	29.00
30.00	Administrative Costs	1,120,254	457,555	1,577,809	19,922	1,597,731	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,120,254	506,212	1,626,466	-21,845	1,604,621	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,424,462	506,431	3,930,893	-59,945	3,870,948	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period: From 04/01/2017

Worksheet M-1

Component CCN: 14-8506

To 03/31/2018

Date/Time Prepared: 8/23/2018 12:44 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
<b>FACILITY HEALTH CARE STAFF COSTS</b>					
1.00	Physician	0	1,677,435		1.00
2.00	Physician Assistant	0	580,480		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	8,193		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,266,108		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	219		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	219		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,266,327		22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
<b>FACILITY OVERHEAD</b>					
29.00	Facility Costs	-8,325	-1,435		29.00
30.00	Administrative Costs	0	1,597,731		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,325	1,596,296		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,325	3,862,623		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2017 To 03/31/2018	Worksheet M-2 Date/Time Prepared: 8/23/2018 12:44 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	4.26	12,558	4,200	17,892	1.00
2.00	Physician Assistant	5.49	12,883	2,100	11,529	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	9.75	25,441		29,421	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)	9.75	25,441		29,421	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,266,327	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,266,327	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				1,596,296	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,634,063	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,230,359	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,230,359	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,230,359	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				6,496,686	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2017 To 03/31/2018	Worksheet M-3 Date/Time Prepared: 8/23/2018 12:44 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,496,686	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			309,736	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,186,950	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29,421	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)			29,421	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			210.29	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)	210.29	210.29		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	6,092	2,030		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,281,087	426,889		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	1,707,976		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,248,127		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		1,258,480		16.04
16.05	Total program cost (see instructions)	0	1,258,480		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		134,876		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		222,650		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,258,480		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		156,203		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,414,683		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)		1,414,683		26.00
26.01	Sequestration adjustment (see instructions)		28,294		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		848,057		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)		538,332		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: 14-1324 Component CCN: 14-8506	Period: From 04/01/2017 To 03/31/2018	Worksheet M-4 Date/Time Prepared: 8/23/2018 12:44 pm
		Title XVIII	RHC I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,266,108	2,266,108	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002663	0.006312	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6,035	14,304	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	55,170	32,540	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	61,205	46,844	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,266,327	2,266,327	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,230,359	4,230,359	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027006	0.020670	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	114,245	87,442	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	175,450	134,286	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	324	768	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	541.51	174.85	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	148	435	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	80,143	76,060	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)		309,736	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)		156,203	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2017 To 03/31/2018	Worksheet M-5 Date/Time Prepared: 8/23/2018 12:44 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		816,688	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		06/22/2017	31,369	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)		31,369	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		848,057	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		538,332	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,386,389	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00