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: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/16/2018 10:08 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/16/2018 Time: 10:08 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HSHS GOOD SHEPHERD HOSPITAL (14-0019) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	402,672	942	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		54,518		0	10.00
200.00	Total	0	402,672	55,461	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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 SOUTH CEDAR	PO Box:			1.00
2.00	City: SHELBYBILLE	State: IL	Zip Code: 62565-1899	County: SHELBY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HSHS GOOD SHEPHERD HOSPITAL	140019	99914	1	07/01/1966	N	P	N	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	HSHS GOOD SHEPHERD HOSPITAL SWING BE	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HSHS GOOD SHEPHERD HOSPITAL HHS	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HSHS GOOD SHEPHERD HOSPITAL RHC	143446	99914		06/05/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	Y	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	328	0	0	0	58	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	07/01/2017	06/30/2018	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 8:39 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	N	N	N	N	109.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	3,621	113,870	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 8:39 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	148005	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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4936 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62707	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	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)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 8:39 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. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/15/2018 8:39 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/25/2018	Y	09/25/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2018 8:39 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2018 8:39 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,950	0.00	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)		30	10,950	0.00	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)		30	10,950	0.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		30				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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	870	328	1,968			1.00
2.00	HMO and other (see instructions)	0	58				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	447	0	447			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,317	328	2,431			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)	1,317	328	2,431	0.00	129.51	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	2,479	0	3,584	0.00	8.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,707	1,097	6,874	0.00	8.23	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	146.54	27.00
28.00	Observation Bed Days		53	442			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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	282	127	497	1.00
2.00	HMO and other (see instructions)			0	12		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	282	127	497	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/15/2018 8:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	5,403,995	0	5,403,995	289,635.44	18.66	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		57,065	0	57,065	1,071.21	53.27	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		32,305	0	32,305	872.06	37.04	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		290,514	23,421	313,935	20,383.06	15.40	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,429,056	0	2,429,056	17,965.00	135.21	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		278,977	0	278,977	2,743.00	101.71	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		314,852	0	314,852	4,165.88	75.58	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,533,453	0	1,533,453			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		110,031	0	110,031			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		9,936	0	9,936			23.00
24.00	Wage-related costs (RHC/FQHC)		6,640	0	6,640			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		94,819	0	94,819			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/15/2018 8:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	5,303	0	5,303	232.41	22.82	26.00
27.00	Administrative & General	5.00	652,477	0	652,477	43,720.51	14.92	27.00
28.00	Administrative & General under contract (see inst.)		45,725	0	45,725	226.50	201.88	28.00
29.00	Maintenance & Repairs	6.00	266,684	0	266,684	15,061.75	17.71	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	1,054	0	1,054	176.25	5.98	31.00
32.00	Housekeeping	9.00	233,351	-23,421	209,930	18,316.41	11.46	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	203,178	-146,117	57,061	4,580.34	12.46	34.00
35.00	Dietary under contract (see instructions)		35,843	0	35,843	745.00	48.11	35.00
36.00	Cafeteria	11.00	0	146,117	146,117	11,728.87	12.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	207,479	0	207,479	7,315.25	28.36	38.00
39.00	Central Services and Supply	14.00	120,244	0	120,244	7,277.47	16.52	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	224,155	0	224,155	14,004.50	16.01	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/15/2018 8:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		5,396,193	0	5,396,193	288,663.67	18.69	1.00
2.00	Excluded area salaries (see instructions)		290,514	23,421	313,935	20,383.06	15.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,105,679	-23,421	5,082,258	268,280.61	18.94	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,022,885	0	3,022,885	24,873.88	121.53	4.00
5.00	Subtotal wage-related costs (see inst.)		1,628,272	0	1,628,272	0.00	32.04	5.00
6.00	Total (sum of lines 3 thru 5)		9,756,836	-23,421	9,733,415	293,154.49	33.20	6.00
7.00	Total overhead cost (see instructions)		1,995,493	-23,421	1,972,072	123,385.26	15.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV | Date/Time Prepared: 11/15/2018 8:39 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	130,679	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,099,187	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	4,660	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	12,699	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	7,538	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	303,843	17.00
18.00	Medicare Taxes - Employers Portion Only	78,358	18.00
19.00	Unemployment Insurance	23,096	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,660,060	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V | Date/Time Prepared: 11/15/2018 8:39 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,429,056	1,660,060	1.00
2.00	Hospital	2,429,056	1,660,060	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0019 | Component CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-4 | Date/Time Prepared: 11/15/2018 8:39 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	146	6	1	153	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	121.00	7.00	56.00	184.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.54	0.00	1.54	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.15	0.00	0.15	5.00
6.00	Direct Nursing Service			5.70	0.00	5.70	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.57	0.00	0.57	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.48	0.00	0.48	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.31	0.00	0.31	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	830	271	39	8	1,148	21.00
22.00	Skilled Nursing Visit Charges	138,129	45,100	6,490	1,331	191,050	22.00
23.00	Physical Therapy Visits	679	108	8	12	807	23.00
24.00	Physical Therapy Visit Charges	122,894	19,576	1,450	2,175	146,095	24.00
25.00	Occupational Therapy Visits	314	60	0	4	378	25.00
26.00	Occupational Therapy Visit Charges	67,234	12,847	0	856	80,937	26.00
27.00	Speech Pathology Visits	24	11	0	0	35	27.00
28.00	Speech Pathology Visit Charges	4,834	2,215	0	0	7,049	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	235	0	0	0	235	30.00
31.00	Home Health Aide Visits	83	27	0	0	110	31.00
32.00	Home Health Aide Visit Charges	7,214	2,347	0	0	9,561	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,931	477	47	24	2,479	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	340,540	82,085	7,940	4,362	434,927	35.00
36.00	Total Number of Episodes (standard/non outlier)	130		16	2	148	36.00
37.00	Total Number of Outlier Episodes		12		0	12	37.00
38.00	Total Non-Routine Medical Supply Charges	3,438	1,707	160	0	5,305	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/15/2018 8:39 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/13/1993	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	3	3	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	7	7	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	9	9	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	23	23	22.00
23.00		RMA	0	2	2	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	60	60	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	8	8	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	9	9	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	35	35	34.00
35.00		HB2	0	5	5	35.00
36.00		HB1	0	44	44	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	10	10	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	4	4	46.00
47.00		CD2	0	7	7	47.00
48.00		CD1	0	11	11	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	13	13	50.00
51.00		CB2	0	4	4	51.00
52.00		CB1	0	22	22	52.00
53.00		CA2	0	7	7	53.00
54.00		CA1	0	142	142	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/15/2018 8:39 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	22	22	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	447	447	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0019 | Component CCN: 14-3446 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/15/2018 8:39 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			200 SOUTH CEDAR STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE		IL	62565	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0019 | Component CCN: 14-3446 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/15/2018 8:39 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/15/2018 8:39 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.358378	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	875,925	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	5,389,092	6.00
7.00	Medicaid cost (line 1 times line 6)	1,931,332	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,055,407	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,055,407	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	181,411	45,281	226,692	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	65,014	45,281	110,295	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	65,014	45,281	110,295	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)	844,941	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	96,369	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	148,261	27.01
28.00	Non-Medicare bad debt expense (see instructions)	696,680	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	301,567	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	411,862	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,467,269	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		754,758	754,758	-102,655	652,103	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	397,149	397,149	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,303	1,731,688	1,736,991	6,488	1,743,479	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	652,477	2,052,678	2,705,155	-72,258	2,632,897	5.00
6.00	00600	MAINTENANCE & REPAIRS	266,684	204,130	470,814	-60	470,754	6.00
7.00	00700	OPERATION OF PLANT	0	279,072	279,072	-38,650	240,422	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,054	62,922	63,976	0	63,976	8.00
9.00	00900	HOUSEKEEPING	233,351	8,865	242,216	-23,421	218,795	9.00
10.00	01000	DIETARY	203,178	235,944	439,122	-315,798	123,324	10.00
11.00	01100	CAFETERIA	0	0	0	315,798	315,798	11.00
13.00	01300	NURSING ADMINISTRATION	207,479	269,147	476,626	0	476,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,244	9,715	129,959	0	129,959	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,155	21,026	245,181	0	245,181	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	15,425	15,425	0	15,425	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	722,274	281,157	1,003,431	-2,531	1,000,900	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,078	306,143	374,221	-44,403	329,818	50.00
53.00	05300	ANESTHESIOLOGY	0	1,286	1,286	0	1,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	442,302	354,816	797,118	0	797,118	54.00
60.00	06000	LABORATORY	458,030	547,248	1,005,278	-19,955	985,323	60.00
65.00	06500	RESPIRATORY THERAPY	193,614	71,506	265,120	-743	264,377	65.00
66.00	06600	PHYSICAL THERAPY	425,923	17,484	443,407	-547	442,860	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,441	25,441	166	25,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,247	1,001,904	1,016,151	-4,166	1,011,985	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,500	1,471	33,971	0	33,971	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	89,370	706,828	796,198	-4,095	792,103	88.00
90.00	09000	CLINIC	151,687	19,278	170,965	-3,987	166,978	90.00
91.00	09100	EMERGENCY	483,316	952,479	1,435,795	-3,887	1,431,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	118,215	82,010	200,225	-6,187	194,038	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	289,586	77,865	367,451	-3,802	363,649	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		148,184	148,184	-148,184	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,403,067	10,240,470	15,643,537	-75,728	15,567,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	928	467,649	468,577	75,728	544,305	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	5,403,995	10,708,119	16,112,114	0	16,112,114	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-148,184	503,919		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	397,149		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-157,304	1,586,175		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-341,559	2,291,338		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	470,754		6.00
7.00	00700	OPERATION OF PLANT	0	240,422		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,976		8.00
9.00	00900	HOUSEKEEPING	0	218,795		9.00
10.00	01000	DIETARY	0	123,324		10.00
11.00	01100	CAFETERIA	-60,692	255,106		11.00
13.00	01300	NURSING ADMINISTRATION	0	476,626		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	129,959		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,001	233,180		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	15,425		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-48,000	952,900		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	329,818		50.00
53.00	05300	ANESTHESIOLOGY	0	1,286		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	797,118		54.00
60.00	06000	LABORATORY	0	985,323		60.00
65.00	06500	RESPIRATORY THERAPY	-9,078	255,299		65.00
66.00	06600	PHYSICAL THERAPY	0	442,860		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,607		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,011,985		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-14,609	19,362		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	90,174	882,277		88.00
90.00	09000	CLINIC	-6,216	160,762		90.00
91.00	09100	EMERGENCY	-612,400	819,508		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	194,038		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	363,649		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,319,869	14,247,940		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	544,305		192.00
194.00	07950	FARM EXPENSES	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,319,869	14,792,245		200.00

RECLASSIFICATIONS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/15/2018 8:39 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL CENTER RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	23,421	0	1.00
	0		23,421	0	
	C - TELEPHONE EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,613	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	8,613	
	D - WORKER'S COMPENSATION INS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,488	1.00
	0		0	6,488	
	E - RENTAL EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	149,333	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	149,333	
	F - MEDICAL CENTER UTILITLES RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,650	1.00
	0		0	38,650	
	G - PHYSICIAN BUILDING DEPR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,657	1.00
2.00		0.00	0	0	2.00
	0		0	13,657	
	H - DEPRECIATION EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	242,821	1.00
	0		0	242,821	
	J - CAFETERIA EXPENSE RECLASS				
1.00	CAFETERIA	11.00	146,117	169,681	1.00
	0		146,117	169,681	
	K - REAL ESTATE TAX RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	10,634	1.00
	0		0	10,634	
	L - ONCOLOGY PHARMACY COSTS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,821	1.00
	0		0	3,821	
	M - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,184	1.00
	0		0	148,184	
	N - MEDICAL SUPPLIES RECLAS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	166	1.00
	TOTALS		0	166	
	Q - RHC PHYSICIAN READING EKGS				
1.00	RESPIRATORY THERAPY	65.00	404	0	1.00
	0		404	0	
500.00	Grand Total: Increases		169,942	792,048	500.00

RECLASSIFICATIONS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/15/2018 8:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL CENTER RECLASS						
1.00	HOUSEKEEPING	9.00	23,421	0	0		1.00
	0		23,421	0			
	C - TELEPHONE EXPENSE RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	547	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	787	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,691	0		3.00
4.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	10	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	3,578	0		5.00
	0		0	8,613			
	D - WORKER'S COMPENSATION INS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,488	0		1.00
	0		0	6,488			
	E - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,749	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	60	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,531	0		3.00
4.00	OPERATING ROOM	50.00	0	44,403	0		4.00
5.00	LABORATORY	60.00	0	19,955	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,147	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,200	0		7.00
8.00	EMERGENCY	91.00	0	3,887	0		8.00
9.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	6,177	0		9.00
10.00	HOME HEALTH AGENCY	101.00	0	224	0		10.00
	0		0	149,333			
	F - MEDICAL CENTER UTILITLES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	38,650	0		1.00
	0		0	38,650			
	G - PHYSICIAN BUILDING DEPR RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,270	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	387	9		2.00
	0		0	13,657			
	H - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	242,821	9		1.00
	0		0	242,821			
	J - CAFETERIA EXPENSE RECLASS						
1.00	DIETARY	10.00	146,117	169,681	0		1.00
	0		146,117	169,681			
	K - REAL ESTATE TAX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,634	6		1.00
	0		0	10,634			
	L - ONCOLOGY PHARMACY COSTS RECLASS						
1.00	CLINIC	90.00	0	3,821	0		1.00
	0		0	3,821			
	M - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	148,184	11		1.00
	0		0	148,184			
	N - MEDICAL SUPPLIES RECLAS						
1.00	CLINIC	90.00	0	166	0		1.00
	TOTALS		0	166			
	Q - RHC PHYSICIAN READING EKGS						
1.00	RURAL HEALTH CLINIC	88.00	404	0	0		1.00
	0		404	0			
500.00	Grand Total: Decreases		169,942	792,048			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	617,631	0	0	0	0	1.00
2.00	Land Improvements	280,987	1,944	0	1,944	0	2.00
3.00	Buildings and Fixtures	13,665,827	49,301	0	49,301	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,484,957	13,354	0	13,354	0	5.00
6.00	Movable Equipment	10,370,578	106,125	0	106,125	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,419,980	170,724	0	170,724	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,419,980	170,724	0	170,724	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	617,631	0	1.00
2.00	Land Improvements	282,931	0	2.00
3.00	Buildings and Fixtures	13,715,128	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,498,311	0	5.00
6.00	Movable Equipment	10,476,703	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,590,704	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,590,704	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/15/2018 8:39 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	752,215	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	752,215	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	2,543	754,758		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	2,543	754,758		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/15/2018 8:39 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	14,615,690	0	14,615,690	0.493928	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,975,014	0	14,975,014	0.506072	0	2.00
3.00	Total (sum of lines 1-2)	29,590,704	0	29,590,704	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,252	0	5,252	496,124	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,382	0	5,382	242,434	149,333	2.00
3.00	Total (sum of lines 1-2)	10,634	0	10,634	738,558	149,333	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	5,252	2,543	503,919	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,382	0	397,149	2.00
3.00	Total (sum of lines 1-2)	0	0	10,634	2,543	901,068	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/15/2018 8:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-148,184	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-4,399	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-675,694			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	303,291			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,692	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,001	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/15/2018 8:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SELF INSURANCE EXPENSE	A	-157,127	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	DONATIONS	A	-900	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-10,052	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PROMOTIONAL ITEMS	A	-57,079	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	REAL ESTATE TAXES	A	-10,634	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	SWITCHBOARD SALARY EXPENSE	A	-966	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	SWITCHBOARD BENEFIT EXPENSE	A	-177	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	FRA TAX	A	-446,521	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	WELLNESS FOR LIFE REVENUE	B	-14,609	CARDIAC REHABILITATION	76.97	0	33.09
33.10	FOUNDATION AND FUNDRAISING	A	-20,420	ADMINISTRATIVE & GENERAL	5.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,319,869				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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/15/2018 8:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC/SS	445,283	232,166	1.00
2.00	88.00	RURAL HEALTH CLINIC	HSHS MEDICAL GROUP	90,174	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HSHS RELATED PARTY ACTIVITY	298,651	298,651	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	HSHS RELATED PARTY ACTIVITY	48,305	48,305	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			882,413	579,122	5.00

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

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

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

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

6.00	B	HSHS	100.00	HSHS	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/15/2018 8:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	213,117	0		1.00
2.00	90,174	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	303,291			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2018 8:39 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	48,000	48,000	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	9,078	9,078	0	0	0	2.00
3.00	90.00	CLINIC	6,216	6,216	0	0	0	3.00
4.00	91.00	EMERGENCY	891,316	612,339	278,977	211,500	2,743	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			954,610	675,633	278,977		2,743	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	278,916	13,946	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			278,916	13,946	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	48,000		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	9,078		2.00
3.00	90.00	CLINIC	0	0	0	6,216		3.00
4.00	91.00	EMERGENCY	0	278,916	61	612,400		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	278,916	61	675,694		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	503,919	503,919				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	397,149		397,149			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,586,175	5,705	4,497	1,596,377		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,291,338	60,363	47,573	192,684	2,591,958	5.00
6.00	00600	MAINTENANCE & REPAIRS	470,754	12,135	9,564	78,872	571,325	6.00
7.00	00700	OPERATION OF PLANT	240,422	11,675	9,201	0	261,298	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,976	10,199	8,038	312	82,525	8.00
9.00	00900	HOUSEKEEPING	218,795	4,846	3,819	62,087	289,547	9.00
10.00	01000	DIETARY	123,324	15,438	12,167	16,876	167,805	10.00
11.00	01100	CAFETERIA	255,106	5,414	4,267	43,214	308,001	11.00
13.00	01300	NURSING ADMINISTRATION	476,626	4,656	3,670	61,362	546,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	129,959	26,476	20,866	35,562	212,863	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	233,180	11,898	9,377	66,294	320,749	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	15,425	0	0	0	15,425	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	952,900	72,891	57,446	213,611	1,296,848	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	329,818	41,345	32,585	20,134	423,882	50.00
53.00	05300	ANESTHESIOLOGY	1,286	812	640	0	2,738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,118	35,728	28,158	130,811	991,815	54.00
60.00	06000	LABORATORY	985,323	14,125	11,132	135,462	1,146,042	60.00
65.00	06500	RESPIRATORY THERAPY	255,299	9,962	7,852	57,381	330,494	65.00
66.00	06600	PHYSICAL THERAPY	442,860	26,090	20,562	125,967	615,479	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,607	0	0	0	25,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011,985	5,347	4,214	4,214	1,025,760	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	19,362	9,665	7,617	9,612	46,256	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	882,277	32,594	25,688	26,312	966,871	88.00
90.00	09000	CLINIC	160,762	52,370	41,274	44,861	299,267	90.00
91.00	09100	EMERGENCY	819,508	13,563	10,689	142,941	986,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	194,038	12,074	9,516	34,962	250,590	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	363,649	8,548	6,737	85,645	464,579	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,247,940	503,919	397,149	1,589,176	14,240,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	544,305	0	0	7,201	551,506	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,792,245	503,919	397,149	1,596,377	14,792,245	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,591,958					5.00
6.00	00600	MAINTENANCE & REPAIRS	121,379	692,704				6.00
7.00	00700	OPERATION OF PLANT	55,513	18,996	335,807			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,533	16,596	8,272	124,926		8.00
9.00	00900	HOUSEKEEPING	61,515	7,885	3,930	0	362,877	9.00
10.00	01000	DIETARY	35,650	25,119	12,521	0	14,040	10.00
11.00	01100	CAFETERIA	65,435	8,810	4,391	0	4,924	11.00
13.00	01300	NURSING ADMINISTRATION	116,065	7,577	3,777	0	4,235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,223	43,081	21,473	1,742	24,079	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,143	19,360	9,650	0	10,821	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,277	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	275,510	118,603	59,117	78,896	66,291	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90,054	67,275	33,533	3,974	37,602	50.00
53.00	05300	ANESTHESIOLOGY	582	1,321	659	0	739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,712	58,135	28,977	27,956	32,494	54.00
60.00	06000	LABORATORY	243,478	22,983	11,456	0	12,846	60.00
65.00	06500	RESPIRATORY THERAPY	70,214	16,210	8,080	650	9,061	65.00
66.00	06600	PHYSICAL THERAPY	130,759	42,453	21,160	9,828	23,729	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,440	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	217,924	8,700	4,336	0	4,863	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,827	15,726	7,838	0	8,790	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	205,413	53,036	26,436	522	29,644	88.00
90.00	09000	CLINIC	63,580	85,214	42,475	1,358	47,629	90.00
91.00	09100	EMERGENCY	209,626	22,069	11,000	0	12,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	53,238	19,646	9,793	0	10,981	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	98,700	13,909	6,933	0	7,774	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,474,790	692,704	335,807	124,926	362,877	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,168	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,591,958	692,704	335,807	124,926	362,877	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	255,135					10.00
11.00	01100	CAFETERIA	0	391,561				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,644	692,612			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,568	61,932	424,961		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,038	0	759	457,520	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	255,135	68,539	291,369	25,956	154,734	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,279	22,443	42,826	22,062	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,641	0	33,942	44,124	54.00
60.00	06000	LABORATORY	0	41,405	0	203,584	44,124	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,844	114,119	9	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30,070	0	5,246	33,118	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,229	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	18,349	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,441	14,630	699	22,062	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,890	0	9,349	104,178	88.00
90.00	09000	CLINIC	0	13,784	58,596	3,802	0	90.00
91.00	09100	EMERGENCY	0	30,468	129,523	30,680	33,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	30,144	0	6,873	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	36,642	0	5,150	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	255,135	387,397	692,612	424,453	457,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,164	0	508	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	255,135	391,561	692,612	424,961	457,520	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	18,702					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,690,998	0	2,690,998		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	748,930	0	748,930		50.00
53.00	05300	ANESTHESIOLOGY	18,702	24,741	0	24,741		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,467,796	0	1,467,796		54.00
60.00	06000	LABORATORY	0	1,725,918	0	1,725,918		60.00
65.00	06500	RESPIRATORY THERAPY	0	575,681	0	575,681		65.00
66.00	06600	PHYSICAL THERAPY	0	911,842	0	911,842		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	68,276	0	68,276		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,279,932	0	1,279,932		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	129,269	0	129,269		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,399,339	0	1,399,339		88.00
90.00	09000	CLINIC	0	615,705	0	615,705		90.00
91.00	09100	EMERGENCY	0	1,465,520	0	1,465,520		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	381,265	0	381,265		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	633,687	0	633,687		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,702	14,118,899	0	14,118,899		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	673,346	0	673,346		192.00
194.00	07950	FARM EXPENSES	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,702	14,792,245	0	14,792,245		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,705	4,497	10,202	10,202	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,838	60,363	47,573	118,774	1,231	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	12,135	9,564	21,699	504	6.00
7.00	00700	OPERATION OF PLANT	0	11,675	9,201	20,876	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,199	8,038	18,237	2	8.00
9.00	00900	HOUSEKEEPING	0	4,846	3,819	8,665	397	9.00
10.00	01000	DIETARY	0	15,438	12,167	27,605	108	10.00
11.00	01100	CAFETERIA	0	5,414	4,267	9,681	276	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,656	3,670	8,326	392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,476	20,866	47,342	227	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,898	9,377	21,275	424	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	72,891	57,446	130,337	1,366	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,345	32,585	73,930	129	50.00
53.00	05300	ANESTHESIOLOGY	0	812	640	1,452	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,728	28,158	63,886	836	54.00
60.00	06000	LABORATORY	0	14,125	11,132	25,257	866	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,962	7,852	17,814	367	65.00
66.00	06600	PHYSICAL THERAPY	0	26,090	20,562	46,652	805	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	5,347	4,214	9,561	27	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	9,665	7,617	17,282	61	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	32,594	25,688	58,282	168	88.00
90.00	09000	CLINIC	0	52,370	41,274	93,644	287	90.00
91.00	09100	EMERGENCY	0	13,563	10,689	24,252	913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	12,074	9,516	21,590	223	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	8,548	6,737	15,285	547	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,838	503,919	397,149	911,906	10,156	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	46	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,838	503,919	397,149	911,906	10,202	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	120,005					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,620	27,823				6.00
7.00	00700	OPERATION OF PLANT	2,570	763	24,209			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	812	667	596	20,314		8.00
9.00	00900	HOUSEKEEPING	2,848	317	283	0	12,510	9.00
10.00	01000	DIETARY	1,651	1,009	903	0	484	10.00
11.00	01100	CAFETERIA	3,029	354	317	0	170	11.00
13.00	01300	NURSING ADMINISTRATION	5,374	304	272	0	146	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,094	1,730	1,548	283	830	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,155	778	696	0	373	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	152	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,757	4,764	4,261	12,829	2,286	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,169	2,702	2,417	646	1,296	50.00
53.00	05300	ANESTHESIOLOGY	27	53	47	0	25	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,755	2,335	2,089	4,546	1,120	54.00
60.00	06000	LABORATORY	11,272	923	826	0	443	60.00
65.00	06500	RESPIRATORY THERAPY	3,251	651	583	106	312	65.00
66.00	06600	PHYSICAL THERAPY	6,054	1,705	1,526	1,598	818	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252	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	10,089	349	313	0	168	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	455	632	565	0	303	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,510	2,130	1,906	85	1,022	88.00
90.00	09000	CLINIC	2,944	3,423	3,062	221	1,642	90.00
91.00	09100	EMERGENCY	9,705	886	793	0	425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,465	789	706	0	379	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	4,570	559	500	0	268	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,580	27,823	24,209	20,314	12,510	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,425	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	120,005	27,823	24,209	20,314	12,510	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	31,760					10.00
11.00	01100	CAFETERIA	0	13,827				11.00
13.00	01300	NURSING ADMINISTRATION	0	517	15,331			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	514	1,371	55,939		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	990	0	100	27,791	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,760	2,421	6,449	3,417	9,399	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	186	497	5,637	1,340	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,400	0	4,468	2,680	54.00
60.00	06000	LABORATORY	0	1,462	0	26,797	2,680	60.00
65.00	06500	RESPIRATORY THERAPY	0	948	2,526	1	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,062	0	691	2,012	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,901	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	2,415	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	122	324	92	1,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	137	0	1,231	6,328	88.00
90.00	09000	CLINIC	0	487	1,297	501	0	90.00
91.00	09100	EMERGENCY	0	1,076	2,867	4,038	2,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,064	0	905	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,294	0	678	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,760	13,680	15,331	55,872	27,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	147	0	67	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,760	13,827	15,331	55,939	27,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	152					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		222,046	0	222,046		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		92,949	0	92,949		50.00
53.00	05300	ANESTHESIOLOGY		1,604	0	1,604		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		93,115	0	93,115		54.00
60.00	06000	LABORATORY		70,526	0	70,526		60.00
65.00	06500	RESPIRATORY THERAPY		26,559	0	26,559		65.00
66.00	06600	PHYSICAL THERAPY		62,923	0	62,923		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		5,153	0	5,153		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		22,922	0	22,922		73.00
76.00	03950	OTHER ANCILLARY COSTS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		21,176	0	21,176		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		80,799	0	80,799		88.00
90.00	09000	CLINIC		107,508	0	107,508		90.00
91.00	09100	EMERGENCY		46,967	0	46,967		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		28,121	0	28,121		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY		23,701	0	23,701		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	906,069	0	906,069		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		5,685	0	5,685		192.00
194.00	07950	FARM EXPENSES		0	0	0		194.00
200.00		Cross Foot Adjustments	152	152	0	152		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	152	911,906	0	911,906		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	843	843	5,397,724			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	651,509	-2,591,958	12,200,287	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	266,684	0	571,325	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	261,298	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	1,054	0	82,525	8.00
9.00	00900	HOUSEKEEPING	716	716	209,930	0	289,547	9.00
10.00	01000	DIETARY	2,281	2,281	57,061	0	167,805	10.00
11.00	01100	CAFETERIA	800	800	146,117	0	308,001	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	207,479	0	546,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	120,244	0	212,863	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	224,155	0	320,749	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	15,425	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	722,274	0	1,296,848	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	68,078	0	423,882	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	0	2,738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	442,302	0	991,815	54.00
60.00	06000	LABORATORY	2,087	2,087	458,030	0	1,146,042	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	194,018	0	330,494	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	425,923	0	615,479	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	25,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	14,247	0	1,025,760	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	32,500	0	46,256	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	88,966	0	966,871	88.00
90.00	09000	CLINIC	7,738	7,738	151,687	0	299,267	90.00
91.00	09100	EMERGENCY	2,004	2,004	483,316	0	986,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	118,215	0	250,590	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	289,586	0	464,579	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,457	74,457	5,373,375	-2,591,958	11,648,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	24,349	0	551,506	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	503,919	397,149	1,596,377		2,591,958	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.767920	5.333938	0.295750		0.212451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,202		120,005	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001890		0.009836	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	51,707			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	9,308	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	721	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	32,655	10,770	9,308	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	1,645	6,109	0	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	11,571	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	0	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	269	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	4,068	3,855	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	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	216	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	562	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	0	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,902	61,177	51,707	58,954	9,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	692,704	335,807	124,926	362,877	255,135	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.012432	5.489105	2.416037	6.155257	27.410292	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,823	24,209	20,314	12,510	31,760	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.442323	0.395721	0.392868	0.212199	3.412119	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/15/2018 8:39 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	195,588					11.00
13.00	01300	NURSING ADMINISTRATION	7,315	81,382				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,277	7,277	765,565			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,005	0	1,367	9,104		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,236	34,236	46,760	3,079	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,637	2,637	77,150	439	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,801	0	61,146	878	0	54.00
60.00	06000	LABORATORY	20,682	0	366,757	878	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,409	13,409	17	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,020	0	9,450	659	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	67,068	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	33,055	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,719	1,719	1,259	439	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,943	0	16,842	2,073	0	88.00
90.00	09000	CLINIC	6,885	6,885	6,850	0	0	90.00
91.00	09100	EMERGENCY	15,219	15,219	55,269	659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,057	0	12,382	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	18,303	0	9,278	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,508	81,382	764,650	9,104	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,080	0	915	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	391,561	692,612	424,961	457,520	18,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.001968	8.510629	0.555095	50.254833	187.020000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,827	15,331	55,939	27,791	152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.070695	0.188383	0.073069	3.052614	1.520000	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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/15/2018 8:39 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,690,998		2,690,998	0	2,690,998	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	748,930		748,930	0	748,930	50.00
53.00	05300	ANESTHESIOLOGY	24,741		24,741	0	24,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,467,796		1,467,796	0	1,467,796	54.00
60.00	06000	LABORATORY	1,725,918		1,725,918	0	1,725,918	60.00
65.00	06500	RESPIRATORY THERAPY	575,681	0	575,681	0	575,681	65.00
66.00	06600	PHYSICAL THERAPY	911,842	0	911,842	0	911,842	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,276		68,276	0	68,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,279,932		1,279,932	0	1,279,932	73.00
76.00	03950	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	129,269		129,269	0	129,269	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,399,339		1,399,339	0	1,399,339	88.00
90.00	09000	CLINIC	615,705		615,705	0	615,705	90.00
91.00	09100	EMERGENCY	1,465,520		1,465,520	61	1,465,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	493,537		493,537		493,537	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	381,265		381,265	0	381,265	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	633,687		633,687		633,687	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,612,436	0	14,612,436	61	14,612,497	200.00
201.00		Less Observation Beds	493,537		493,537		493,537	201.00
202.00		Total (see instructions)	14,118,899	0	14,118,899	61	14,118,960	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/15/2018 8:39 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,285,094		3,285,094			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,527	1,106,008	1,117,535	0.670162	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	9,225	618,545	627,770	0.039411	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	857,704	12,360,925	13,218,629	0.111040	0.000000	54.00
60.00	06000	LABORATORY	1,243,762	7,810,157	9,053,919	0.190627	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	238,582	1,541,224	1,779,806	0.323452	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	365,201	1,551,002	1,916,203	0.475859	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	309,962	180,339	490,301	0.139253	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,855	1,137,725	1,532,580	0.835149	0.000000	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	240	172,226	172,466	0.749533	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,035,978	1,035,978			88.00
90.00	09000	CLINIC	670	372,619	373,289	1.649406	0.000000	90.00
91.00	09100	EMERGENCY	180,009	2,926,549	3,106,558	0.471750	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,370	578,110	728,480	0.677489	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	321,582	321,582	1.185592	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	636,528	636,528			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,047,201	32,349,517	39,396,718			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,047,201	32,349,517	39,396,718			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/15/2018 8:39 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.670162	50.00
53.00	05300	ANESTHESIOLOGY	0.039411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111040	54.00
60.00	06000	LABORATORY	0.190627	60.00
65.00	06500	RESPIRATORY THERAPY	0.323452	65.00
66.00	06600	PHYSICAL THERAPY	0.475859	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.139253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.835149	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.749533	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	1.649406	90.00
91.00	09100	EMERGENCY	0.471770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677489	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.185592	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	222,046	0	222,046	2,410	92.14	30.00
200.00	Total (lines 30 through 199)	222,046		222,046	2,410		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	870	80,162	30.00
200.00	Total (lines 30 through 199)	870	80,162	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,949	1,117,535	0.083173	11,527	959	50.00
53.00	05300	ANESTHESIOLOGY	1,604	627,770	0.002555	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,115	13,218,629	0.007044	802,578	5,653	54.00
60.00	06000	LABORATORY	70,526	9,053,919	0.007790	1,073,982	8,366	60.00
65.00	06500	RESPIRATORY THERAPY	26,559	1,779,806	0.014922	184,101	2,747	65.00
66.00	06600	PHYSICAL THERAPY	62,923	1,916,203	0.032837	184,253	6,050	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,153	490,301	0.010510	230,902	2,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,922	1,532,580	0.014956	244,152	3,652	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	21,176	172,466	0.122784	123	15	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	80,799	1,035,978	0.077993	0	0	88.00
90.00	09000	CLINIC	107,508	373,289	0.288002	0	0	90.00
91.00	09100	EMERGENCY	46,967	3,106,558	0.015119	139,130	2,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,724	728,480	0.055903	106,157	5,934	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	28,121	321,582	0.087446	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	701,046	35,475,096		2,976,905	37,907	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,410	0.00	870	30.00
200.00		Total (lines 30 through 199)		0	2,410		870	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	18,702	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
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
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	18,702	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,117,535	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	18,702	0	627,770	0.029791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,218,629	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,053,919	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,779,806	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,916,203	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	490,301	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,532,580	0.000000	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	172,466	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,035,978	0.000000	88.00
90.00	09000	CLINIC	0	0	0	373,289	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,106,558	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	728,480	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	321,582	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	18,702	0	35,475,096		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/15/2018 8:39 pm

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,527	0	893,769	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	802,578	0	5,215,408	0	54.00
60.00	06000	LABORATORY	0.000000	1,073,982	0	1,558,417	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	184,101	0	787,826	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	184,253	0	336,324	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	230,902	0	67,946	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	244,152	0	1,091,993	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	123	0	89,605	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	32,337	0	90.00
91.00	09100	EMERGENCY	0.000000	139,130	0	992,597	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	106,157	0	322,817	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		2,976,905	0	11,389,039	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.670162	893,769	0	0	598,970	50.00
53.00	05300	ANESTHESIOLOGY	0.039411	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111040	5,215,408	0	0	579,119	54.00
60.00	06000	LABORATORY	0.190627	1,558,417	0	0	297,076	60.00
65.00	06500	RESPIRATORY THERAPY	0.323452	787,826	0	0	254,824	65.00
66.00	06600	PHYSICAL THERAPY	0.475859	336,324	0	0	160,043	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.139253	67,946	0	0	9,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.835149	1,091,993	0	0	911,977	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.749533	89,605	0	0	67,162	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.649406	32,337	0	0	53,337	90.00
91.00	09100	EMERGENCY	0.471750	992,597	0	0	468,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677489	322,817	0	0	218,705	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.185592	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		11,389,039	0	0	3,618,933	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		11,389,039	0	0	3,618,933	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
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
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,873	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,410	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,968	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	224	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)	223	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	870	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)	224	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)	223	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,690,998	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,690,998	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,690,998	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,116.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	971,442	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)	971,442	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	822,505	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,793,947	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)	80,162	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	37,907	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	118,069	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,675,878	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)	442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,116.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	493,537	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	222,046	2,690,998	0.082514	493,537	40,724	90.00
91.00	Nursing School cost	0	2,690,998	0.000000	493,537	0	91.00
92.00	Allied health cost	0	2,690,998	0.000000	493,537	0	92.00
93.00	All other Medical Education	0	2,690,998	0.000000	493,537	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,833,035		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.670162	11,527	7,725	50.00
53.00	05300	ANESTHESIOLOGY	0.039411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111040	802,578	89,118	54.00
60.00	06000	LABORATORY	0.190627	1,073,982	204,730	60.00
65.00	06500	RESPIRATORY THERAPY	0.323452	184,101	59,548	65.00
66.00	06600	PHYSICAL THERAPY	0.475859	184,253	87,678	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.139253	230,902	32,154	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.835149	244,152	203,903	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.749533	123	92	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.649406	0	0	90.00
91.00	09100	EMERGENCY	0.471770	139,130	65,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677489	106,157	71,920	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.185592	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,976,905	822,505	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)		2,976,905		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0019 | Component CCN: 14-U019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.670162	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.039411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.111040	55,126	6,121	54.00
60.00	06000	LABORATORY	0.190627	169,780	32,365	60.00
65.00	06500	RESPIRATORY THERAPY	0.323452	54,481	17,622	65.00
66.00	06600	PHYSICAL THERAPY	0.475859	180,948	86,106	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.139253	64,406	8,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.835149	102,311	85,445	73.00
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.749533	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.649406	0	0	90.00
91.00	09100	EMERGENCY	0.471770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.677489	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.185592	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		627,052	236,628	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)		627,052		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/15/2018 8:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	353,659	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,060,979	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,004	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	27.52	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.61	31.00
32.00	Sum of lines 30 and 31	24.87	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.73	33.00
34.00	Disproportionate share adjustment (see instructions)	34,411	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000009437	0.000013853	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	56,412	93,738	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	14,219	70,111	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	84,330		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,534,383		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	1,774,083		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		1,774,083	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		113,469	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,887,552	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,887,552	61.00
62.00	Deductibles billed to program beneficiaries		268,544	62.00
63.00	Coinsurance billed to program beneficiaries		1,005	63.00
64.00	Allowable bad debts (see instructions)		60,968	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		39,629	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		60,968	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,657,632	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-11,303	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/15/2018 8:39 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	110,149	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	351,386	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,107,864	71.00
71.01	Sequestration adjustment (see instructions)		42,157	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		1,663,035	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		402,672	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/15/2018 8:39 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	353,659	0	353,659		353,659	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,060,979	0		1,060,979	1,060,979	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,004	0	0	1,004	1,004	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0973	0.0973	0.0973	0.0973		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	34,411	0	8,603	25,808	34,411	11.00
11.01	Uncompensated care payments	36.00	84,330	0	14,218	70,112	84,330	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,534,383	0	376,480	1,157,903	1,534,383	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,774,083	0	441,905	1,332,178	1,774,083	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,774,083	0	441,905	1,332,178	1,774,083	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	113,469	0	9,326	104,143	113,469	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/15/2018 8:39 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	451,231	1,436,321	1,887,552	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	113,469	0	9,326	104,143	113,469	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	113,469	0	9,326	104,143	113,469	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.244107	0.244643		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			110,149		110,149	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				351,386	351,386	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/15/2018 8:39 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	353,659	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,060,979		1,414,638	1,414,638	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,004	0	1,004	1,004	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0973	0.0973	0.0973		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	34,411	0	34,411	34,411	11.00
11.01	Uncompensated care payments	36.00	84,330	14,219	70,111	84,330	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,534,383	14,219	1,520,164	1,534,383	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,774,083	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,774,083	0	1,774,083	1,774,083	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	113,469	9,326	104,143	113,469	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,326	1,878,226	1,887,552	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/15/2018 8:39 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	113,469	9,326	104,143	113,469	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	113,469	9,326	104,143	113,469	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	110,149	110,149		110,149	28.00
29.00	Low volume adjustment on or after October 1	70.97	351,386		351,386	351,386	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-11,303	0	-11,303	-11,303	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/15/2018 8:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,618,933	2.00
3.00	OPPS payments	2,082,735	3.00
4.00	Outlier payment (see instructions)	7,505	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	2,090,240	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	427,592	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,662,648	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,662,648	30.00
31.00	Primary payer payments	273	31.00
32.00	Subtotal (line 30 minus line 31)	1,662,375	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	60,199	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	39,129	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,199	36.00
37.00	Subtotal (see instructions)	1,701,504	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,701,504	40.00
40.01	Sequestration adjustment (see instructions)	34,030	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,666,532	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	942	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,533,300		1,674,032	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	06/25/2018	151,368	06/25/2018	8,611	3.01
3.02		03/29/2018	3,730	03/29/2018	3,290	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	02/01/2018	25,363	02/01/2018	19,401	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)		129,735		-7,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,663,035		1,666,532	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		402,672		942	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,065,707		1,667,474	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: 14-0019 | Component CCN: 14-U019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		115,998		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		115,998		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		115,998		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 - SWING BEDS | Provider CCN: 14-0019 | Component CCN: 14-U019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	136,542	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)			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	447	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)	136,542	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	136,542	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)	136,542	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,177	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)	118,365	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)	118,365	0	19.00
19.01	Sequestration adjustment (see instructions)	2,367	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	115,998	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)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

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

Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/15/2018 8:39 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	999,837	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	3,178,289	0	0	0	4.00
5.00	Other receivable	-24,520	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	335,172	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	242,896	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,731,674	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	617,632	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-451,990	0	0	0	14.00
15.00	Buildings	13,715,128	0	0	0	15.00
16.00	Accumulated depreciation	-11,573,313	0	0	0	16.00
17.00	Leasehold improvements	282,931	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,805	0	0	0	19.00
20.00	Accumulated depreciation	-3,984,899	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	-4,580	0	0	0	22.00
23.00	Major movable equipment	14,968,209	0	0	0	23.00
24.00	Accumulated depreciation	-9,529,506	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,183,091	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,229,508	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	21,119,840	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	492,382	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,612,222	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,573,404	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	978,311	0	0	0	37.00
38.00	Salaries, wages, and fees payable	102,156	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	300,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,299,827	0	0	0	43.00
44.00	Other current liabilities	1,853,123	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,533,417	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,393,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	494,313	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,887,313	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,420,730	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,152,674				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)	20,152,674	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,573,404	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/15/2018 8:39 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		20,740,885		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		412,079				2.00
3.00	Total (sum of line 1 and line 2)		21,152,964		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)		21,152,964		0		11.00
12.00	CHANGE IN NET ASSETS	1,000,290		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)		1,000,290		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,152,674		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	CHANGE IN NET ASSETS		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: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/15/2018 8:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,659,426		2,659,426	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	600,046		600,046	5.00
6.00	Swing bed - NF	21,621		21,621	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)	3,281,093		3,281,093	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,281,093		3,281,093	17.00
18.00	Ancillary services	3,431,058	26,661,101	30,092,159	18.00
19.00	Outpatient services	331,049	3,890,737	4,221,786	19.00
20.00	RURAL HEALTH CLINIC	0	1,035,978	1,035,978	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		636,528	636,528	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	PRO FEES	0	72,209	72,209	27.00
27.01	PHYSICIAN OFFICES	0	154,804	154,804	27.01
27.02	DME	0	321,582	321,582	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,043,200	32,772,939	39,816,139	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,112,114		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,112,114		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0019 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/15/2018 8:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	39,816,139	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,980,551	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,835,588	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,112,114	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,276,526	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	641,818	6.00
7.00	Income from investments	575,264	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	60,692	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	8,218	17.00
18.00	Revenue from sale of medical records and abstracts	2,899	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	113,001	22.00
23.00	Governmental appropriations	0	23.00
24.00	NURSING SRVCS	4,333	24.00
24.01	PRO FEES	-89,680	24.01
24.02	MISC INC	29,060	24.02
24.03	MISC INC	343,000	24.03
25.00	Total other income (sum of lines 6-24)	1,688,605	25.00
26.00	Total (line 5 plus line 25)	412,079	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)	412,079	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0019 HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H | Date/Time Prepared: 11/15/2018 8:39 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	62,193	0	18,467	0	15,932	96,592	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	147,243	0	0	0	0	147,243	6.00
7.00	Physical Therapy	39,325	0	0	0	0	39,325	7.00
8.00	Occupational Therapy	30,391	0	0	0	0	30,391	8.00
9.00	Speech Pathology	3,859	0	0	0	0	3,859	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	6,575	0	0	0	0	6,575	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	43,466	0	43,466	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	289,586	0	18,467	43,466	15,932	367,451	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-3,802	92,790	0	92,790			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	147,243	0	147,243			6.00
7.00	Physical Therapy	0	39,325	0	39,325			7.00
8.00	Occupational Therapy	0	30,391	0	30,391			8.00
9.00	Speech Pathology	0	3,859	0	3,859			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	6,575	0	6,575			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	43,466	0	43,466			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-3,802	363,649	0	363,649			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	92,790	0	0	0	0	92,790	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	147,243	0	0	0	0	147,243	6.00
7.00	Physical Therapy	39,325	0	0	0	0	39,325	7.00
8.00	Occupational Therapy	30,391	0	0	0	0	30,391	8.00
9.00	Speech Pathology	3,859	0	0	0	0	3,859	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	6,575	0	0	0	0	6,575	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	43,466	0	0	0	0	43,466	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	363,649	0	0	0	0	363,649	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	92,790		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	50,443	197,686	6.00
7.00	Physical Therapy	13,472	52,797	7.00
8.00	Occupational Therapy	10,411	40,802	8.00
9.00	Speech Pathology	1,322	5,181	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	2,252	8,827	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	14,890	58,356	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		363,649	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part II | Date/Time Prepared: 11/15/2018 8:39 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-92,790	270,859	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	147,243	6.00
7.00	Physical Therapy	0	0	0	0	0	39,325	7.00
8.00	Occupational Therapy	0	0	0	0	0	30,391	8.00
9.00	Speech Pathology	0	0	0	0	0	3,859	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	6,575	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	43,466	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-92,790	270,859	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		92,790	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.342577	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	8,548	6,737	18,394	33,679	7,155	1.00
2.00	Skilled Nursing Care	197,686	0	0	43,547	241,233	51,249	2.00
3.00	Physical Therapy	52,797	0	0	11,630	64,427	13,688	3.00
4.00	Occupational Therapy	40,802	0	0	1,945	42,747	9,082	4.00
5.00	Speech Pathology	5,181	0	0	1,141	6,322	1,343	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	8,827	0	0	8,988	17,815	3,785	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	58,356	0	0	0	58,356	12,398	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	363,649	8,548	6,737	85,645	464,579	98,700	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	13,909	6,933	0	7,774	0	36,642	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	13,909	6,933	0	7,774	0	36,642	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	5,150	0	0	111,242	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	292,482	0	2.00
3.00	Physical Therapy	0	0	0	0	78,115	0	3.00
4.00	Occupational Therapy	0	0	0	0	51,829	0	4.00
5.00	Speech Pathology	0	0	0	0	7,665	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	21,600	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	70,754	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	5,150	0	0	633,687	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	111,242						1.00
2.00	Skilled Nursing Care	292,482	62,277	354,759				2.00
3.00	Physical Therapy	78,115	16,633	94,748				3.00
4.00	Occupational Therapy	51,829	11,036	62,865				4.00
5.00	Speech Pathology	7,665	1,632	9,297				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	21,600	4,599	26,199				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	70,754	15,065	85,819				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	633,687	111,242	633,687				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.212926					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part II | Date/Time Prepared: 11/15/2018 8:39 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,263	1,263	62,193	0	33,679	1,263	1.00
2.00	Skilled Nursing Care	0	0	147,243	0	241,233	0	2.00
3.00	Physical Therapy	0	0	39,325	0	64,427	0	3.00
4.00	Occupational Therapy	0	0	6,575	0	42,747	0	4.00
5.00	Speech Pathology	0	0	3,859	0	6,322	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	30,391	0	17,815	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	58,356	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	1,263	289,586		464,579	1,263	20.00
21.00	Total cost to be allocated	8,548	6,737	85,645		98,700	13,909	21.00
22.00	Unit cost multiplier	6.768013	5.334125	0.295750		0.212450	11.012668	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,263	0	1,263	0	18,303	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	0	1,263	0	18,303	0	20.00
21.00	Total cost to be allocated	6,933	0	7,774	0	36,642	0	21.00
22.00	Unit cost multiplier	5.489311	0.000000	6.155186	0.000000	2.001967	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0019
HHA CCN: 14-7622

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

Worksheet H-2
Part II
Date/Time Prepared:
11/15/2018 8:39 pm

Home Health Agency I

PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		14.00	16.00	19.00			
1.00	Administrative and General	9,278	0	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19)	9,278	0	0			20.00
21.00	Total cost to be allocated	5,150	0	0			21.00
22.00	Unit cost multiplier	0.555077	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0019 HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	354,759		354,759	1,692	209.67	1.00
2.00	Physical Therapy	3.00	94,748	0	94,748	1,182	80.16	2.00
3.00	Occupational Therapy	4.00	62,865	0	62,865	518	121.36	3.00
4.00	Speech Pathology	5.00	9,297	0	9,297	39	238.38	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	26,199		26,199	153	171.24	6.00
7.00	Total (sum of lines 1-6)		547,868	0	547,868	3,584		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,148			8.00
9.00	Physical Therapy		99914	0	807			9.00
10.00	Occupational Therapy		99914	0	378			10.00
11.00	Speech Pathology		99914	0	35			11.00
12.00	Medical Social Services		99914	0	1			12.00
13.00	Home Health Aide		99914	0	110			13.00
14.00	Total (sum of lines 8-13)			0	2,479			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	739	739	5,305	0.139303	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,148		0	240,701		1.00
2.00	Physical Therapy	0	807		0	64,689		2.00
3.00	Occupational Therapy	0	378		0	45,874		3.00
4.00	Speech Pathology	0	35		0	8,343		4.00
5.00	Medical Social Services	0	1		0	0		5.00
6.00	Home Health Aide	0	110		0	18,836		6.00
7.00	Total (sum of lines 1-6)	0	2,479		0	378,443		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	440,233	0	0	61,326	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	240,701						1.00
2.00	Physical Therapy	64,689						2.00
3.00	Occupational Therapy	45,874						3.00
4.00	Speech Pathology	8,343						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	18,836						6.00
7.00	Total (sum of lines 1-6)	378,443						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.475859	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.139253	5,305	739	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.835149	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/15/2018 8:39 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	348,041	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	43,491	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,853	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,784	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	9,432	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	409,601	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	409,601	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	409,601	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	409,601	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	409,601	31.00
31.01	Sequestration adjustment (see instructions)	0	8,192	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	401,408	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0019 | HHA CCN: 14-7622 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-5 | Date/Time Prepared: 11/15/2018 8:39 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		401,408	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		401,408	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		401,409	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0019	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/15/2018 8:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	113,469	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	5.39	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	113,469	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0019 | Component CCN: 14-3446 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/15/2018 8:39 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	220,495	220,495	-404	220,091	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	57,066	200,618	257,684	0	257,684	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	77	199,457	199,534	0	199,534	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)	57,143	620,570	677,713	-404	677,309	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	9,936	9,936	0	9,936	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	32	32	0	32	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,968	9,968	0	9,968	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	57,143	630,538	687,681	-404	687,277	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	190	190	0	190	29.00
30.00	Administrative Costs	32,227	76,100	108,327	-3,691	104,636	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,227	76,290	108,517	-3,691	104,826	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	89,370	706,828	796,198	-4,095	792,103	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0019 | Component CCN: 14-3446 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/15/2018 8:39 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	90,174	310,265		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	257,684		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	199,534		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)	90,174	767,483		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	9,936		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	32		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,968		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	90,174	777,451		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	190		29.00
30.00	Administrative Costs	0	104,636		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	104,826		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	90,174	882,277		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0019 | Component CCN: 14-3446 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/15/2018 8:39 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.80	1,981	4,200	3,360		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.52	4,893	2,100	3,192		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.32	6,874		6,552	6,874	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.32	6,874			6,874	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					777,451	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)					777,451	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)					104,826	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					517,062	15.00
16.00	Total overhead (sum of lines 14 and 15)					621,888	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					621,888	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					621,888	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,399,339	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0019 Component CCN: 14-3446	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/15/2018 8:39 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,399,339	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			8,879	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,390,460	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,874	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)			6,874	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.28	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)	202.28	202.28		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	853	854		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	172,545	172,747		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	345,292		16.00
16.01	Total program charges (see instructions)(from contractor's records)		219,751		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.)		252,735		16.04
16.05	Total program cost (see instructions)	0	252,735		16.05
17.00	Primary payer amounts		65		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,373		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,075		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		252,670		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,597		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		257,267		22.00
23.00	Allowable bad debts (see instructions)		27,094		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		17,611		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,094		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)		274,878		26.00
26.01	Sequestration adjustment (see instructions)		5,498		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		214,862		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)		54,518		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-0019 Component CCN: 14-3446	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/15/2018 8:39 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)	767,483	767,483	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002469	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,895	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	3,038	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	4,933	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	777,451	777,451	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	621,888	621,888	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.006345	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	3,946	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	8,879	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	197	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	45.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	102	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	4,597	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)		8,879	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)		4,597	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0019 Component CCN: 14-3446	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/15/2018 8:39 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		214,862	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		214,862	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		54,518	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		269,380	7.00

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