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: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 2:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 2:40 pm
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 SARAH BUSH LINCOLN HEALTH CENTER (14-0189) 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)

PRESIDENT & CEO
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	-169,063	419,837	0	0	1.00
2.00	Subprovider - IPF	0	72,200	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
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		1,156		0	10.00
10.01	RURAL HEALTH CLINIC II	0		1,566		0	10.01
10.02	RURAL HEALTH CLINIC III	0		4,212		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		2,920		0	10.03
10.04	RURAL HEALTH CLINIC V	0		1,372		0	10.04
200.00	Total	0	-96,863	431,063	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:31 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 HEALTH CENTER DRIVE	PO Box: 372			1.00
2.00	City: MATTOON	State: IL	Zip Code: 61920-	County: COLES	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	SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF	SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	LINCOLNLAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	LINCOLNLAND HOSPICE OF SBLHS	141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC	CASEY RHC	143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SULLIVAN RHC	143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NEOGA RHC	143435	99914		05/31/1997	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	NEWTON RHC	148541	99914		07/01/2014	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	MARTINSVILLE RHC	148555	99914		07/01/2015	N	O	N	15.04
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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:31 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	
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.	2,458	919	0	0	461	192	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 2:31 pm

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:31 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.	Y			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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 2:31 pm

		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.	Y	N	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.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:31 pm

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

		1.00	2.00	3.00	
	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:	4,724,084	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 2:31 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2015	12/31/2015	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 2:31 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	10/09/2018	Y	10/09/2018
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 2:31 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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	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.	BARB	IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509	BIPPOLITO@SBLHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 2:31 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.	REIMB. ACCOUNTANT		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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 2:31 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	77	28,105	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)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	32.00	9	3,285	0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		86	31,390	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	0	0		0	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	116.00	0	0			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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		106				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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 2:31 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)	8,583	2,581	16,215			1.00
2.00	HMO and other (see instructions)	2,069	742				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8,583	2,581	16,215			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	1,058	321	1,931			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		194	1,167			13.00
14.00	Total (see instructions)	9,641	3,096	19,313	0.00	1,824.92	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,771	2,174	5,095	0.00	32.25	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	19,390	0	25,509	0.00	59.48	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	29.86	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	839	0	2,909	0.00	4.42	26.00
26.01	RURAL HEALTH CLINIC II	827	0	3,688	0.00	6.18	26.01
26.02	RURAL HEALTH CLINIC III	2,428	0	6,452	0.00	7.97	26.02
26.03	RURAL HEALTH CLINIC IV	1,146	0	5,646	0.00	8.21	26.03
26.04	RURAL HEALTH CLINIC V	3,828	0	14,496	0.00	12.32	26.04
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	1,985.61	27.00
28.00	Observation Bed Days		1,054	5,020			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	192	458			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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 2:31 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	2,812	1,149	6,319	1.00
2.00	HMO and other (see instructions)			546	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,812	1,149	6,319	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	243	479	1,015	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					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	0.00					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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2018 2:31 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	147,096,165	0	147,096,165	4,130,085.00	35.62	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		1,948,276	0	1,948,276	20,981.00	92.86	3.00
4.00	Physician-Part A - Administrative		61,219	0	61,219	1,103.00	55.50	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		20,733,942	0	20,733,942	78,500.00	264.13	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,008,255	0	1,008,255	15,089.00	66.82	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)		49,485,947	-48,002	49,437,945	1,193,908.00	41.41	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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)		27,307,186	0	27,307,186			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		9,370,458	0	9,370,458			19.00
20.00	Non-physician anesthetist Part A		521,785	0	521,785			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		51,923	0	51,923			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		2,368,496	0	2,368,496			23.00
24.00	Wage-related costs (RHC/FQHC)		162,977	0	162,977			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	838,288	0	838,288	23,750.00	35.30	26.00
27.00	Administrative & General	5.00	15,485,601	0	15,485,601	453,771.00	34.13	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/26/2018 2:31 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	
28.00	Administrative & General under contract (see inst.)		603,326	0	603,326	2,034.00	296.62	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,320,128	0	1,320,128	54,309.00	24.31	30.00
31.00	Laundry & Linen Service	8.00	31,772	0	31,772	2,174.00	14.61	31.00
32.00	Housekeeping	9.00	1,652,169	0	1,652,169	111,201.00	14.86	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,535,105	-1,137,206	397,899	25,531.00	15.58	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,137,206	1,137,206	72,970.00	15.58	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,874,939	0	1,874,939	56,818.00	33.00	38.00
39.00	Central Services and Supply	14.00	599,218	0	599,218	36,947.00	16.22	39.00
40.00	Pharmacy	15.00	1,699,730	0	1,699,730	43,894.00	38.72	40.00
41.00	Medical Records & Medical Records Library	16.00	1,643,026	0	1,643,026	141,221.00	11.63	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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/26/2018 2:31 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)		124,009,018	0	124,009,018	4,017,549.00	30.87	1.00
2.00	Excluded area salaries (see instructions)		49,485,947	-48,002	49,437,945	1,193,908.00	41.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)		74,523,071	48,002	74,571,073	2,823,641.00	26.41	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		27,359,109	0	27,359,109	0.00	36.69	5.00
6.00	Total (sum of lines 3 thru 5)		101,882,180	48,002	101,930,182	2,823,641.00	36.10	6.00
7.00	Total overhead cost (see instructions)		27,283,302	0	27,283,302	1,024,620.00	26.63	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/26/2018 2:31 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	6,185,458	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	174,472	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)	21,849,306	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	799,503	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	305,533	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	32,671	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	282,033	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,520,832	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	8,130,439	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	93,693	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	408,885	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	39,782,825	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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 2:31 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	0	39,782,825	1.00
2.00	Hospital	0	27,307,186	2.00
3.00	Subprovider - IPF	0	1,012,607	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	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,116,662	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	471,052	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	3,590	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	56,094	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	103,293	14.04
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	9,712,341	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-4 | Date/Time Prepared: 11/26/2018 2:31 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	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,097.00	165.00	617.00	1,879.00	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)		0.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			2.00	0.00	2.00	4.00
5.00	Other Administrative Personnel			14.50	0.00	14.50	5.00
6.00	Direct Nursing Service			28.74	0.00	28.74	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			6.52	0.00	6.52	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.65	0.00	2.65	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.28	0.00	0.28	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.01	0.00	1.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.78	0.00	2.78	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	7,671	3,012	350	367	11,400	21.00
22.00	Skilled Nursing Visit Charges	1,382,101	531,318	69,102	67,307	2,049,828	22.00
23.00	Physical Therapy Visits	3,330	473	66	197	4,066	23.00
24.00	Physical Therapy Visit Charges	621,127	86,269	12,500	36,830	756,726	24.00
25.00	Occupational Therapy Visits	1,360	226	17	104	1,707	25.00
26.00	Occupational Therapy Visit Charges	249,472	41,193	3,155	19,233	313,053	26.00
27.00	Speech Pathology Visits	105	22	6	3	136	27.00
28.00	Speech Pathology Visit Charges	19,415	4,065	1,214	546	25,240	28.00
29.00	Medical Social Service Visits	144	45	3	11	203	29.00
30.00	Medical Social Service Visit Charges	32,112	10,035	669	2,453	45,269	30.00
31.00	Home Health Aide Visits	1,316	519	4	39	1,878	31.00
32.00	Home Health Aide Visit Charges	102,648	40,482	312	3,042	146,484	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	13,926	4,297	446	721	19,390	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)	2,406,875	713,362	86,952	129,411	3,336,600	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,074		152	48	1,274	36.00
37.00	Total Number of Outlier Episodes		139		16	155	37.00
38.00	Total Non-Routine Medical Supply Charges	165,765	127,909	15,430	4,912	314,016	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			412 NW 3RD		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CASEY		IL	62420	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			07:30	16:30	07:30	11.00

		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?				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		CLARK				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	16:30	07:30	16:30	07:30	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 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	07:30	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7 HAWTHORNE LANE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SULLIVAN		IL	61951	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?				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		MOULTRIE				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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-3998

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

Worksheet S-8
Date/Time Prepared:
11/26/2018 2:31 pm

RHC II | 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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			650 OAK AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEOGA		IL	62447	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			08:30	17:30	08:30	11.00

		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?				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		CUMBERLAND				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	17:30	08:30	17:30	08:30	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			910 SOUTH VAN BUREN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEWTON		IL	62448	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			07:00	17:00	07:00	11.00

		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?				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		JASPER				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	17:00	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC IV | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			890 E RIDGELAWN RD		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MARTINSVILLE		IL	62442	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?					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		CLARK				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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC V | 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-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
11/26/2018 2:31 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	21,614	1,038	807	23,459	11.00
12.00	Hospice Inpatient Respite Care	76	0	10	86	12.00
13.00	Hospice General Inpatient Care	33	8	1	42	13.00
14.00	Total Hospice Days	21,723	1,046	818	23,587	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 2:31 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)	0.195640	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	23,232,731	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	10,022,863	5.00
6.00	Medicaid charges	141,589,833	6.00
7.00	Medicaid cost (line 1 times line 6)	27,700,635	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)	0	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)	0	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	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)	7,128,594	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,140,553	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,754,696	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,373,898	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,665,492	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,665,492	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,665,492	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:31 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		0	0	8,436,353	8,436,353	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	13,664,987	13,664,987	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	838,288	31,562,973	32,401,261	194,059	32,595,320	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,485,601	47,937,305	63,422,906	-23,386,957	40,035,949	5.00
7.00	00700	OPERATION OF PLANT	1,320,128	3,838,901	5,159,029	-26,560	5,132,469	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,772	574,943	606,715	0	606,715	8.00
9.00	00900	HOUSEKEEPING	1,652,169	504,616	2,156,785	0	2,156,785	9.00
10.00	01000	DIETARY	1,535,105	1,373,165	2,908,270	-2,154,447	753,823	10.00
11.00	01100	CAFETERIA	0	0	0	2,154,447	2,154,447	11.00
13.00	01300	NURSING ADMINISTRATION	1,874,939	388,415	2,263,354	-4,664	2,258,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	599,218	978,458	1,577,676	-70,580	1,507,096	14.00
15.00	01500	PHARMACY	1,699,730	16,763,925	18,463,655	-16,368,500	2,095,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,643,026	482,230	2,125,256	-6,743	2,118,513	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,977,163	2,604,448	20,581,611	-1,127,244	19,454,367	30.00
32.00	03200	CORONARY CARE UNIT	1,727,686	1,126,485	2,854,171	-1,699	2,852,472	32.00
40.00	04000	SUBPROVIDER - IPF	3,908,508	331,574	4,240,082	37,071	4,277,153	40.00
43.00	04300	NURSERY	0	22,735	22,735	502,542	525,277	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,894,345	3,004,446	8,898,791	-141,854	8,756,937	50.00
51.00	05100	RECOVERY ROOM	1,379,176	283,700	1,662,876	-11,499	1,651,377	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	76,446	76,446	762,638	839,084	52.00
53.00	05300	ANESTHESIOLOGY	5,190,703	1,030,889	6,221,592	114,550	6,336,142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,176,440	1,534,761	8,711,201	-456,627	8,254,574	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,535,353	752,392	3,287,745	34,836	3,322,581	55.00
56.00	05600	RADIOISOTOPE	1,261,949	1,303,851	2,565,800	292,802	2,858,602	56.00
57.00	05700	CT SCAN	478,515	516,027	994,542	104,429	1,098,971	57.00
58.00	05800	MRI	391,001	515,557	906,558	101,164	1,007,722	58.00
59.00	05900	CARDIAC CATHETERIZATION	741,345	524,093	1,265,438	-6,964	1,258,474	59.00
60.00	06000	LABORATORY	5,149,747	5,253,736	10,403,483	38,641	10,442,124	60.00
65.00	06500	RESPIRATORY THERAPY	1,137,917	472,658	1,610,575	-1,088	1,609,487	65.00
66.00	06600	PHYSICAL THERAPY	2,598,683	1,260,745	3,859,428	-15,851	3,843,577	66.00
67.00	06700	OCCUPATIONAL THERAPY	526,135	63,348	589,483	0	589,483	67.00
68.00	06800	SPEECH PATHOLOGY	814,846	547,919	1,362,765	-801	1,361,964	68.00
69.00	06900	ELECTROCARDIOLOGY	1,493,398	3,334,030	4,827,428	19,851	4,847,279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,393,987	1,365,147	2,759,134	30,398	2,789,532	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,887,634	3,887,634	0	3,887,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,710,518	7,710,518	0	7,710,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,200,638	16,200,638	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	645,868	58,351	704,219	-16,855	687,364	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	274,987	135,151	410,138	55,787	465,925	88.00
88.01	08801	RURAL HEALTH CLINIC II	392,139	133,426	525,565	9,655	535,220	88.01
88.02	08802	RURAL HEALTH CLINIC III	744,553	148,958	893,511	17,598	911,109	88.02
88.03	08803	RURAL HEALTH CLINIC IV	488,334	163,850	652,184	9,528	661,712	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,229,021	265,824	1,494,845	-3,857	1,490,988	88.04
91.00	09100	EMERGENCY	9,286,951	2,749,179	12,036,130	392,016	12,428,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,885,975	812,964	4,698,939	-8,679	4,690,260	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,639,735	1,048,565	2,688,300	-2,660	2,685,640	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,044,436	147,444,338	254,488,774	-640,139	253,848,635	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,852,724	7,978,566	43,831,290	839,597	44,670,887	192.00
194.00	07950	WELLNESS	564,875	358,775	923,650	-5,891	917,759	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	1,348,188	1,866,301	3,214,489	-3,324	3,211,165	194.01
194.02	07951	LIFELINE	15,333	101,016	116,349	0	116,349	194.02
194.03	07952	OCCUPATIONAL HEALTH	704,154	181,806	885,960	-188,154	697,806	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,566,455	944,641	2,511,096	-2,089	2,509,007	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	147,096,165	158,875,443	305,971,608	0	305,971,608	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 2:31 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	-1,718,229	6,718,124		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	13,664,987		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-409,484	32,185,836		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,725,866	34,310,083		5.00
7.00	00700	OPERATION OF PLANT	0	5,132,469		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	606,715		8.00
9.00	00900	HOUSEKEEPING	-630	2,156,155		9.00
10.00	01000	DIETARY	0	753,823		10.00
11.00	01100	CAFETERIA	-1,027,893	1,126,554		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,258,690		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,507,096		14.00
15.00	01500	PHARMACY	0	2,095,155		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-60,065	2,058,448		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,603,167	14,851,200		30.00
32.00	03200	CORONARY CARE UNIT	0	2,852,472		32.00
40.00	04000	SUBPROVIDER - IPF	-2,143,961	2,133,192		40.00
43.00	04300	NURSERY	0	525,277		43.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,756,937		50.00
51.00	05100	RECOVERY ROOM	0	1,651,377		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	839,084		52.00
53.00	05300	ANESTHESIOLOGY	-5,821,171	514,971		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,342,143	3,912,431		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,335,216	1,987,365		55.00
56.00	05600	RADIOISOTOPE	0	2,858,602		56.00
57.00	05700	CT SCAN	0	1,098,971		57.00
58.00	05800	MRI	0	1,007,722		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,258,474		59.00
60.00	06000	LABORATORY	-693,831	9,748,293		60.00
65.00	06500	RESPIRATORY THERAPY	-178,047	1,431,440		65.00
66.00	06600	PHYSICAL THERAPY	-22	3,843,555		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	589,483		67.00
68.00	06800	SPEECH PATHOLOGY	-861,142	500,822		68.00
69.00	06900	ELECTROCARDIOLOGY	-3,119,358	1,727,921		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-740,710	2,048,822		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,887,634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,710,518		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,200,638		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	687,364		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	465,925		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	535,220		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	911,109		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	661,712		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,490,988		88.04
91.00	09100	EMERGENCY	-6,312,425	6,115,721		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	4,690,260		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	2,685,640		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-39,093,360	214,755,275		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,670,887		192.00
194.00	07950	WELLNESS	0	917,759		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	3,211,165		194.01
194.02	07951	LIFELINE	0	116,349		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	697,806		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	2,509,007		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-39,093,360	266,878,248		200.00

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:31 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,200,638	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	16,200,638	
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION				
1.00	RADIOISOTOPE	56.00	170,776	122,026	1.00
2.00	CT SCAN	57.00	64,756	48,295	2.00
3.00	MRI	58.00	52,913	48,251	3.00
	0		288,445	218,572	
	C - CAP REL COSTS-MOVABLE EQUIP				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	649,915	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
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
	0		0	649,915	
	D - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,516,830	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,015,072	2.00
	0		0	19,531,902	
	E - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	1,137,206	1,017,241	1.00
	0		1,137,206	1,017,241	
	F - EMPLOYEE PHYSICALS/BENF EXP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	186,218	1.00
	0		0	186,218	
	G - EAP BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,611	1.00
	0		0	14,611	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,919,523	1.00
	0		0	1,919,523	
	I - NURSRY/L&D EXP				
1.00	NURSERY	43.00	502,542	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	762,638	0	2.00
	0		1,265,180	0	
	J - PHYSN PROF LIAB EXP				
1.00	ADULTS & PEDIATRICS	30.00	0	157,306	1.00
2.00	SUBPROVIDER - IPF	40.00	0	41,203	2.00
3.00	ANESTHESIOLOGY	53.00	0	119,856	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	37,450	4.00

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:31 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	LABORATORY	60.00	0	13,109	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	25,280	6.00
7.00	EMERGENCY	91.00	0	397,019	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	5,244	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	10,487	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	18,352	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	10,487	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	935,978	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	52,435	13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	35,582	14.00
15.00	RURAL HEALTH CLINIC V	88.04	0	31,461	15.00
	0		0	1,891,249	
	K - RHC V-LAB STAFF EXPENSE				
1.00	LABORATORY	60.00	29,857	2,141	1.00
	0		29,857	2,141	
	L - RHC S&W RECLASS-TOL TO CASEY				
1.00	RURAL HEALTH CLINIC	88.00	48,002	3,590	1.00
	TOTALS		48,002	3,590	
500.00	Grand Total: Increases		2,768,690	41,635,600	500.00

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:31 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	16,176,839	0		1.00
2.00	RECOVERY ROOM	51.00	0	9,648	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	5,306	0		3.00
4.00	CT SCAN	57.00	0	8,622	0		4.00
5.00	OPERATING ROOM	50.00	0	223	0		5.00
	0		0	16,200,638			
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	288,445	218,572	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		288,445	218,572			
	C - CAP REL COSTS-MOVABLE EQUIP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,770	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	44,283	14		2.00
3.00	OPERATION OF PLANT	7.00	0	26,560	14		3.00
4.00	NURSING ADMINISTRATION	13.00	0	4,664	14		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	70,580	14		5.00
6.00	PHARMACY	15.00	0	191,661	14		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,743	14		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	19,370	14		8.00
9.00	CORONARY CARE UNIT	32.00	0	1,699	14		9.00
10.00	SUBPROVIDER - IPF	40.00	0	4,132	14		10.00
12.00	OPERATING ROOM	50.00	0	141,631	14		12.00
13.00	RECOVERY ROOM	51.00	0	1,851	14		13.00
14.00	RURAL HEALTH CLINIC IV	88.03	0	959	14		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,045	14		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,614	14		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	6,964	14		17.00
18.00	LABORATORY	60.00	0	6,466	14		18.00
19.00	RESPIRATORY THERAPY	65.00	0	1,088	14		19.00
20.00	PHYSICAL THERAPY	66.00	0	15,851	14		20.00
21.00	SPEECH PATHOLOGY	68.00	0	801	14		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	5,429	14		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,184	14		23.00
24.00	RURAL HEALTH CLINIC	88.00	0	1,049	14		24.00
25.00	RURAL HEALTH CLINIC II	88.01	0	832	14		25.00
26.00	RURAL HEALTH CLINIC III	88.02	0	754	14		26.00
27.00	EMERGENCY	91.00	0	5,003	14		27.00
28.00	HOME HEALTH AGENCY	101.00	0	8,679	14		28.00
29.00	HOSPICE	116.00	0	2,660	14		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	44,789	14		30.00
31.00	WELLNESS	194.00	0	5,891	14		31.00
32.00	OCCUPATIONAL HEALTH	194.03	0	1,936	14		32.00
33.00	MISC. NONREIMBURSABLE	194.05	0	2,089	14		33.00
34.00	OTHER NONREIMB PROGRAM: PEACE MEAL	194.01	0	3,324	14		34.00
35.00	RURAL HEALTH CLINIC V	88.04	0	3,320	0		35.00
36.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	2,244	14		36.00
	0		0	649,915			
	D - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,531,902	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	19,531,902			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	1,137,206	1,017,241	0		1.00
	0		1,137,206	1,017,241			
	F - EMPLOYEE PHYSICALS/BENF EXP						
1.00	OCCUPATIONAL HEALTH	194.03	0	186,218	0		1.00
	0		0	186,218			
	G - EAP BENEFITS						
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	14,611	0		1.00
	0		0	14,611			
	H - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,919,523	11		1.00
	0		0	1,919,523			
	I - NURSRY/L&D EXP						
1.00	ADULTS & PEDIATRICS	30.00	1,265,180	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,265,180	0			

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 2:31 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - PHYSN PROF LIAB EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,891,249	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	0		0	1,891,249			
	K - RHC V-LAB STAFF EXPENSE						
1.00	RURAL HEALTH CLINIC V	88.04	29,857	2,141	0		1.00
	0		29,857	2,141			
	L - RHC S&W RECLASS-TOL TO CASEY						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	48,002	3,590	0		1.00
	TOTALS		48,002	3,590			
500.00	Grand Total: Decreases		2,768,690	41,635,600			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 2:31 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	3,677,396	0	0	0	0	1.00
2.00	Land Improvements	12,362,902	1,801,571	0	1,801,571	101,520	2.00
3.00	Buildings and Fixtures	160,435,469	5,203,912	0	5,203,912	1,080,480	3.00
4.00	Building Improvements	541,780	38,513	0	38,513	310,281	4.00
5.00	Fixed Equipment	19,047,998	274,969	0	274,969	473,669	5.00
6.00	Movable Equipment	110,388,261	11,269,717	0	11,269,717	2,293,778	6.00
7.00	HIT designated Assets	684,552	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	307,138,358	18,588,682	0	18,588,682	4,259,728	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	307,138,358	18,588,682	0	18,588,682	4,259,728	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,677,396	0	1.00
2.00	Land Improvements	14,062,953	0	2.00
3.00	Buildings and Fixtures	164,558,901	0	3.00
4.00	Building Improvements	270,012	0	4.00
5.00	Fixed Equipment	18,849,298	0	5.00
6.00	Movable Equipment	119,364,200	0	6.00
7.00	HIT designated Assets	684,552	0	7.00
8.00	Subtotal (sum of lines 1-7)	321,467,312	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	321,467,312	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/26/2018 2:31 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	0	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)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 2:31 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	5,902,328	0	5,902,328	0.344309	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,240,217	0	11,240,217	0.655691	0	2.00
3.00	Total (sum of lines 1-2)	17,142,545	0	17,142,545	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	0	0	0	6,516,830	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,015,072	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,531,902	0	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	201,294	0	0	0	6,718,124	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	649,915	13,664,987	2.00
3.00	Total (sum of lines 1-2)	201,294	0	0	649,915	20,383,111	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 2:31 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-27,115,796			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-979,217	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	-60,065	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	B	-630	HOUSEKEEPING	9.00	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVESTMENT INCOME	B	-1,718,229	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 2:31 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	
35.00	A&G OTHER INCOME	B	-307,130	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	DIETARY OUTREACH REVENUE	B	0	DIETARY	10.00	0	36.00
37.00	FACILITIES SVC OTHER REV	B	0	OPERATION OF PLANT	7.00	0	37.00
38.00	W&C (BABY CLASSES), 4W MISC	B	-8,686	ADULTS & PEDIATRICS	30.00	0	38.00
38.01	XRAY OTHER REVENUE	B	-150	RADIOLOGY-DIAGNOSTIC	54.00	0	38.01
39.00	PHYSICAL THERAPY OTHER REV	B	-22	PHYSICAL THERAPY	66.00	0	39.00
39.01	MEDICAID ASSESSMENT TAX	A	-5,384,239	ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.00	SPEECH/AUDIO OTHER REV	B	-861,142	SPEECH PATHOLOGY	68.00	0	41.00
42.00	RADIOLOGY-THERAP MISC REV	B	-1,162	RADIOLOGY-THERAPEUTIC	55.00	0	42.00
43.00	EMERGENCY (EMS)OTHER REV	B	-103,659	EMERGENCY	91.00	0	43.00
44.00	AHA/IIHA LOBBYING FEES	A	-34,497	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	CRNA S&W (EMPLYEES)	A	-2,060,576	ANESTHESIOLOGY	53.00	0	45.00
45.01	CRNA (BENEFIT EXP)	A	-409,484	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	CAFETERIA REV/OTHER	B	-48,676	CAFETERIA	11.00	0	45.02
45.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-39,093,360				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 2:31 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	AGGREGATE-ADULTS & PEDIATRICS	4,594,481	4,594,481	0	142,500	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	2,143,961	2,143,961	0	138,700	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	3,760,595	3,760,595	0	167,500	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,341,993	4,341,993	0	167,500	0	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	1,334,054	1,334,054	0	217,600	0	5.00
6.00	60.00	DR. A	700,552	679,333	21,219	208,000	63	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	178,047	178,047	0	159,800	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	3,119,358	3,119,358	0	159,800	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	740,710	740,710	0	159,800	0	9.00
10.00	91.00	DR. B	464,692	424,692	40,000	159,800	1,040	10.00
11.00	91.00	AGGREGATE-EMERGENCY	5,784,074	5,784,074	0	159,800	0	11.00
200.00			27,162,517	27,101,298	61,219		1,103	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	51,381	0	157,306	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	11,231	0	41,203	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	32,255	0	119,856	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	9,740	0	52,435	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	37,450	5.00
6.00	60.00	DR. A	6,300	315	794	24	13,109	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	4,055	0	35,582	9.00
10.00	91.00	DR. B	79,900	3,995	1,850	159	12,407	10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	28,936	0	384,612	11.00
200.00			86,200	4,310	140,242	183	853,960	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	4,594,481		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	2,143,961		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	3,760,595		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	4,341,993		4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	1,334,054		5.00
6.00	60.00	DR. A	397	6,721	14,498	693,831		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	178,047		7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	3,119,358		8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	740,710		9.00
10.00	91.00	DR. B	1,068	81,127	0	424,692		10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	0	5,784,074		11.00
200.00			1,465	87,848	14,498	27,115,796		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 2:31 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	6,718,124	6,718,124				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,664,987		13,664,987			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,185,836	46,069	3,322	32,235,227		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,310,083	565,080	5,613,279	3,413,026	43,901,468	5.00
7.00	00700	OPERATION OF PLANT	5,132,469	425,097	605,726	290,956	6,454,248	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	606,715	13,375	0	7,003	627,093	8.00
9.00	00900	HOUSEKEEPING	2,156,155	12,644	22,098	364,138	2,555,035	9.00
10.00	01000	DIETARY	753,823	82,667	46,442	87,697	970,629	10.00
11.00	01100	CAFETERIA	1,126,554	50,036	18,804	250,640	1,446,034	11.00
13.00	01300	NURSING ADMINISTRATION	2,258,690	25,402	85,011	413,237	2,782,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,507,096	80,337	218,067	132,068	1,937,568	14.00
15.00	01500	PHARMACY	2,095,155	36,963	28,782	374,620	2,535,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,058,448	48,537	45,092	362,123	2,514,200	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,851,200	679,030	798,721	3,683,321	20,012,272	30.00
32.00	03200	CORONARY CARE UNIT	2,852,472	61,811	149,431	380,782	3,444,496	32.00
40.00	04000	SUBPROVIDER - IPF	2,133,192	109,782	22,731	861,435	3,127,140	40.00
43.00	04300	NURSERY	525,277	7,770	59,263	110,760	703,070	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,756,937	472,740	1,599,130	1,299,114	12,127,921	50.00
51.00	05100	RECOVERY ROOM	1,651,377	107,074	74,222	303,970	2,136,643	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	839,084	17,720	42,879	168,085	1,067,768	52.00
53.00	05300	ANESTHESIOLOGY	514,971	8,136	104,815	1,144,031	1,771,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,912,431	190,585	679,644	1,518,114	6,300,774	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,987,365	356,939	756,063	558,792	3,659,159	55.00
56.00	05600	RADIOISOTOPE	2,858,602	24,533	609,478	315,773	3,808,386	56.00
57.00	05700	CT SCAN	1,098,971	19,218	79,572	119,737	1,317,498	57.00
58.00	05800	MRI	1,007,722	25,730	14,700	97,839	1,145,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,258,474	35,792	291,426	163,392	1,749,084	59.00
60.00	06000	LABORATORY	9,748,293	154,679	407,573	1,141,585	11,452,130	60.00
65.00	06500	RESPIRATORY THERAPY	1,431,440	19,458	68,498	250,797	1,770,193	65.00
66.00	06600	PHYSICAL THERAPY	3,843,555	181,076	35,375	572,750	4,632,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,483	5,315	4,879	115,960	715,637	67.00
68.00	06800	SPEECH PATHOLOGY	500,822	38,966	30,770	179,592	750,150	68.00
69.00	06900	ELECTROCARDIOLOGY	1,727,921	72,201	109,509	329,145	2,238,776	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,048,822	57,819	27,679	307,235	2,441,555	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,887,634	0	0	0	3,887,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,710,518	0	0	0	7,710,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,200,638	0	0	0	16,200,638	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	687,364	34,243	3,236	142,349	867,192	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	465,925	166,921	21,264	71,187	725,297	88.00
88.01	08801	RURAL HEALTH CLINIC II	535,220	83,284	8,130	86,427	713,061	88.01
88.02	08802	RURAL HEALTH CLINIC III	911,109	32,631	11,406	164,099	1,119,245	88.02
88.03	08803	RURAL HEALTH CLINIC IV	661,712	36,963	18,886	107,629	825,190	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,490,988	106,495	43,198	264,296	1,904,977	88.04
91.00	09100	EMERGENCY	6,115,721	224,702	109,927	2,046,844	8,497,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,690,260	50,250	36,863	856,469	5,633,842	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,685,640	18,891	574	361,398	3,066,503	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,755,275	4,786,961	12,906,465	23,418,415	203,248,778	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,670,887	1,375,906	483,307	7,891,351	54,421,451	192.00
194.00	07950	WELLNESS	917,759	293,440	81,600	124,498	1,417,297	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	3,211,165	0	122,365	297,141	3,630,671	194.01
194.02	07951	LIFELINE	116,349	3,023	0	3,379	122,751	194.02
194.03	07952	OCCUPATIONAL HEALTH	697,806	36,661	5,663	155,196	895,326	194.03
194.05	07954	MISC. NONREIMBURSABLE	2,509,007	222,133	65,587	345,247	3,141,974	194.05
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)	266,878,248	6,718,124	13,664,987	32,235,227	266,878,248	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	43,901,468					5.00
7.00	00700	OPERATION OF PLANT	1,270,764	7,725,012				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,467	18,126	768,686			8.00
9.00	00900	HOUSEKEEPING	503,056	17,136	35,637	3,110,864		9.00
10.00	01000	DIETARY	191,105	112,032	10,466	0	1,284,232	10.00
11.00	01100	CAFETERIA	284,707	67,810	0	93,552	0	11.00
13.00	01300	NURSING ADMINISTRATION	547,809	34,425	0	24,213	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	381,484	108,874	14,676	35,219	0	14.00
15.00	01500	PHARMACY	499,213	50,093	0	5,503	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	495,016	65,778	0	14,308	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,940,176	920,233	216,686	25,864	1,020,027	30.00
32.00	03200	CORONARY CARE UNIT	678,180	83,768	18,076	61,634	42,903	32.00
40.00	04000	SUBPROVIDER - IPF	615,696	148,778	20,491	90,800	178,070	40.00
43.00	04300	NURSERY	138,426	10,531	5,851	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,387,842	640,666	121,788	856,548	6,491	50.00
51.00	05100	RECOVERY ROOM	420,679	145,109	48,957	88,049	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,231	24,014	16,868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	348,876	11,026	0	5,503	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,547	258,284	36,562	53,104	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	720,444	483,730	0	220,121	0	55.00
56.00	05600	RADIOISOTOPE	749,826	33,248	22,170	22,012	0	56.00
57.00	05700	CT SCAN	259,400	26,045	14,242	13,207	0	57.00
58.00	05800	MRI	225,632	34,869	5,747	5,503	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	344,374	48,506	15,189	27,515	0	59.00
60.00	06000	LABORATORY	2,254,787	209,624	273	116,939	0	60.00
65.00	06500	RESPIRATORY THERAPY	348,530	26,369	0	18,710	0	65.00
66.00	06600	PHYSICAL THERAPY	912,134	245,398	6,377	115,564	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,900	7,203	0	11,006	0	67.00
68.00	06800	SPEECH PATHOLOGY	147,696	52,807	81	16,509	0	68.00
69.00	06900	ELECTROCARDIOLOGY	440,788	97,848	7,976	112,262	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	480,713	78,357	796	37,421	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	765,428	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,518,108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,189,711	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	170,740	46,407	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	142,802	226,214	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	140,393	112,868	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	220,366	44,222	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	162,470	50,093	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	375,067	144,324	0	0	0	88.04
91.00	09100	EMERGENCY	1,672,996	304,520	149,773	332,108	36,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,109,236	68,100	0	22,012	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	603,758	25,601	0	8,805	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,373,573	5,083,036	768,682	2,433,991	1,284,232	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,714,946	1,876,682	4	484,267	0	192.00
194.00	07950	WELLNESS	279,049	397,675	0	96,303	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	714,836	0	0	0	0	194.01
194.02	07951	LIFELINE	24,168	4,096	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	176,279	49,684	0	22,012	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	618,617	313,839	0	74,291	0	194.05
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)	43,901,468	7,725,012	768,686	3,110,864	1,284,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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	1,892,103					11.00
13.00	01300	NURSING ADMINISTRATION	42,047	3,430,834				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,031	0	2,505,852			14.00
15.00	01500	PHARMACY	32,703	0	0	3,123,032		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,062	0	0	0	3,145,364	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	411,124	1,615,599	0	0	748,562	30.00
32.00	03200	CORONARY CARE UNIT	43,604	184,674	0	0	12,506	32.00
40.00	04000	SUBPROVIDER - IPF	49,833	176,575	0	0	21,844	40.00
43.00	04300	NURSERY	14,016	67,172	0	0	5,429	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,796	620,595	0	0	235,823	50.00
51.00	05100	RECOVERY ROOM	35,818	149,383	0	0	46,675	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,245	97,279	0	0	19,097	52.00
53.00	05300	ANESTHESIOLOGY	23,359	2,387	0	0	48,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,406	0	0	0	126,310	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,818	0	0	0	46,525	55.00
56.00	05600	RADIOISOTOPE	26,474	0	0	0	148,067	56.00
57.00	05700	CT SCAN	14,016	0	0	0	249,735	57.00
58.00	05800	MRI	10,901	0	0	0	95,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,458	0	0	0	89,421	59.00
60.00	06000	LABORATORY	147,942	0	0	0	183,570	60.00
65.00	06500	RESPIRATORY THERAPY	32,703	0	0	0	44,203	65.00
66.00	06600	PHYSICAL THERAPY	48,276	0	0	0	80,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,344	0	0	0	9,291	67.00
68.00	06800	SPEECH PATHOLOGY	17,130	0	0	0	9,952	68.00
69.00	06900	ELECTROCARDIOLOGY	42,047	0	0	0	30,419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,130	0	0	0	22,058	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	902,107	0	107,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,603,745	0	111,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,123,032	385,177	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23,359	0	0	0	381	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,178	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,710	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	2,777	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	2,423	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	5,774	88.04
91.00	09100	EMERGENCY	141,713	517,170	0	0	213,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	23,359	0	0	0	17,665	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	9,344	0	0	0	21,394	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,551,058	3,430,834	2,505,852	3,123,032	3,145,364	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	295,884	0	0	0	0	192.00
194.00	07950	WELLNESS	21,802	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	15,573	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	7,786	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,892,103	3,430,834	2,505,852	3,123,032	3,145,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	28,910,543	0	28,910,543		30.00
32.00	03200	CORONARY CARE UNIT	4,569,841	0	4,569,841		32.00
40.00	04000	SUBPROVIDER - IPF	4,429,227	0	4,429,227		40.00
43.00	04300	NURSERY	944,495	0	944,495		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	17,114,470	0	17,114,470		50.00
51.00	05100	RECOVERY ROOM	3,071,313	0	3,071,313		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,455,502	0	1,455,502		52.00
53.00	05300	ANESTHESIOLOGY	2,211,379	0	2,211,379		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,080,987	0	8,080,987		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,165,797	0	5,165,797		55.00
56.00	05600	RADIOISOTOPE	4,810,183	0	4,810,183		56.00
57.00	05700	CT SCAN	1,894,143	0	1,894,143		57.00
58.00	05800	MRI	1,524,334	0	1,524,334		58.00
59.00	05900	CARDIAC CATHETERIZATION	2,286,547	0	2,286,547		59.00
60.00	06000	LABORATORY	14,365,265	0	14,365,265		60.00
65.00	06500	RESPIRATORY THERAPY	2,240,708	0	2,240,708		65.00
66.00	06600	PHYSICAL THERAPY	6,040,930	0	6,040,930		66.00
67.00	06700	OCCUPATIONAL THERAPY	893,381	0	893,381		67.00
68.00	06800	SPEECH PATHOLOGY	994,325	0	994,325		68.00
69.00	06900	ELECTROCARDIOLOGY	2,970,116	0	2,970,116		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,078,030	0	3,078,030		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,662,341	0	5,662,341		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,944,243	0	10,944,243		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,898,558	0	22,898,558		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,108,079	0	1,108,079		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,095,491	0	1,095,491		88.00
88.01	08801	RURAL HEALTH CLINIC II	968,032	0	968,032		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,386,610	0	1,386,610		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,040,176	0	1,040,176		88.03
88.04	08805	RURAL HEALTH CLINIC V	2,430,142	0	2,430,142		88.04
91.00	09100	EMERGENCY	11,866,178	0	11,866,178		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	6,874,214	0	6,874,214		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	3,735,405	0	3,735,405		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,060,985	0	187,060,985		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,793,234	0	67,793,234		192.00
194.00	07950	WELLNESS	2,212,126	0	2,212,126		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	4,345,507	0	4,345,507		194.01
194.02	07951	LIFELINE	151,015	0	151,015		194.02
194.03	07952	OCCUPATIONAL HEALTH	1,158,874	0	1,158,874		194.03
194.05	07954	MISC. NONREIMBURSABLE	4,156,507	0	4,156,507		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	266,878,248	0	266,878,248		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 2:31 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	46,069	3,322	49,391	49,391	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	565,080	5,613,279	6,178,359	5,234	5.00
7.00	00700	OPERATION OF PLANT	0	425,097	605,726	1,030,823	446	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,375	0	13,375	11	8.00
9.00	00900	HOUSEKEEPING	0	12,644	22,098	34,742	558	9.00
10.00	01000	DIETARY	0	82,667	46,442	129,109	134	10.00
11.00	01100	CAFETERIA	0	50,036	18,804	68,840	384	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,402	85,011	110,413	634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,337	218,067	298,404	203	14.00
15.00	01500	PHARMACY	0	36,963	28,782	65,745	575	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,537	45,092	93,629	555	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	679,030	798,721	1,477,751	5,649	30.00
32.00	03200	CORONARY CARE UNIT	0	61,811	149,431	211,242	584	32.00
40.00	04000	SUBPROVIDER - IPF	0	109,782	22,731	132,513	1,321	40.00
43.00	04300	NURSERY	0	7,770	59,263	67,033	170	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	472,740	1,599,130	2,071,870	1,992	50.00
51.00	05100	RECOVERY ROOM	0	107,074	74,222	181,296	466	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,720	42,879	60,599	258	52.00
53.00	05300	ANESTHESIOLOGY	0	8,136	104,815	112,951	1,754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190,585	679,644	870,229	2,328	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	356,939	756,063	1,113,002	857	55.00
56.00	05600	RADIOISOTOPE	0	24,533	609,478	634,011	484	56.00
57.00	05700	CT SCAN	0	19,218	79,572	98,790	184	57.00
58.00	05800	MRI	0	25,730	14,700	40,430	150	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	35,792	291,426	327,218	251	59.00
60.00	06000	LABORATORY	0	154,679	407,573	562,252	1,751	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,458	68,498	87,956	385	65.00
66.00	06600	PHYSICAL THERAPY	0	181,076	35,375	216,451	878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,315	4,879	10,194	178	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,966	30,770	69,736	275	68.00
69.00	06900	ELECTROCARDIOLOGY	0	72,201	109,509	181,710	505	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	57,819	27,679	85,498	471	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	34,243	3,236	37,479	218	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	166,921	21,264	188,185	109	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	83,284	8,130	91,414	133	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	32,631	11,406	44,037	252	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	36,963	18,886	55,849	165	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	106,495	43,198	149,693	405	88.04
91.00	09100	EMERGENCY	0	224,702	109,927	334,629	3,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	50,250	36,863	87,113	1,313	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	18,891	574	19,465	554	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,786,961	12,906,465	17,693,426	35,913	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,375,906	483,307	1,859,213	12,059	192.00
194.00	07950	WELLNESS	0	293,440	81,600	375,040	191	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	122,365	122,365	456	194.01
194.02	07951	LIFELINE	0	3,023	0	3,023	5	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	36,661	5,663	42,324	238	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	222,133	65,587	287,720	529	194.05
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)	0	6,718,124	13,664,987	20,383,111	49,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	6,183,593					5.00
7.00	00700	OPERATION OF PLANT	178,989	1,210,258				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,391	2,840	33,617			8.00
9.00	00900	HOUSEKEEPING	70,856	2,685	1,559	110,400		9.00
10.00	01000	DIETARY	26,917	17,552	458	0	174,170	10.00
11.00	01100	CAFETERIA	40,101	10,624	0	3,320	0	11.00
13.00	01300	NURSING ADMINISTRATION	77,160	5,393	0	859	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,733	17,057	642	1,250	0	14.00
15.00	01500	PHARMACY	70,315	7,848	0	195	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,724	10,305	0	508	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	554,980	144,171	9,474	918	138,338	30.00
32.00	03200	CORONARY CARE UNIT	95,523	13,124	791	2,187	5,819	32.00
40.00	04000	SUBPROVIDER - IPF	86,722	23,309	896	3,222	24,150	40.00
43.00	04300	NURSERY	19,498	1,650	256	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	336,332	100,372	5,326	30,399	880	50.00
51.00	05100	RECOVERY ROOM	59,253	22,734	2,141	3,125	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,611	3,762	738	0	0	52.00
53.00	05300	ANESTHESIOLOGY	49,140	1,727	0	195	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	174,733	40,465	1,599	1,885	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	101,476	75,785	0	7,812	0	55.00
56.00	05600	RADIOISOTOPE	105,614	5,209	970	781	0	56.00
57.00	05700	CT SCAN	36,537	4,080	623	469	0	57.00
58.00	05800	MRI	31,781	5,463	251	195	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,506	7,599	664	976	0	59.00
60.00	06000	LABORATORY	317,590	32,841	12	4,150	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,091	4,131	0	664	0	65.00
66.00	06600	PHYSICAL THERAPY	128,476	38,446	279	4,101	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,846	1,128	0	391	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,803	8,273	4	586	0	68.00
69.00	06900	ELECTROCARDIOLOGY	62,086	15,330	349	3,984	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,709	12,276	35	1,328	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,812	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,828	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	449,276	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,049	7,270	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,114	35,440	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	19,775	17,683	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	31,039	6,928	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	22,884	7,848	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	52,829	22,611	0	0	0	88.04
91.00	09100	EMERGENCY	235,644	47,708	6,550	11,786	4,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	156,238	10,669	0	781	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	85,040	4,011	0	312	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,419,021	796,347	33,617	86,379	174,170	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,509,216	294,014	0	17,186	0	192.00
194.00	07950	WELLNESS	39,304	62,303	0	3,418	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	100,686	0	0	0	0	194.01
194.02	07951	LIFELINE	3,404	642	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	24,829	7,784	0	781	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	87,133	49,168	0	2,636	0	194.05
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)	6,183,593	1,210,258	33,617	110,400	174,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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	123,269					11.00
13.00	01300	NURSING ADMINISTRATION	2,739	197,198				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,826	0	373,115			14.00
15.00	01500	PHARMACY	2,131	0	0	146,809		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,652	0	0	0	178,373	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,785	92,862	0	0	42,140	30.00
32.00	03200	CORONARY CARE UNIT	2,841	10,615	0	0	711	32.00
40.00	04000	SUBPROVIDER - IPF	3,247	10,149	0	0	1,242	40.00
43.00	04300	NURSERY	913	3,861	0	0	309	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,609	35,671	0	0	13,404	50.00
51.00	05100	RECOVERY ROOM	2,333	8,586	0	0	2,653	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,319	5,591	0	0	1,085	52.00
53.00	05300	ANESTHESIOLOGY	1,522	137	0	0	2,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,261	0	0	0	7,179	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,333	0	0	0	2,644	55.00
56.00	05600	RADIOISOTOPE	1,725	0	0	0	8,416	56.00
57.00	05700	CT SCAN	913	0	0	0	14,195	57.00
58.00	05800	MRI	710	0	0	0	5,439	58.00
59.00	05900	CARDIAC CATHETERIZATION	812	0	0	0	5,083	59.00
60.00	06000	LABORATORY	9,638	0	0	0	10,434	60.00
65.00	06500	RESPIRATORY THERAPY	2,131	0	0	0	2,512	65.00
66.00	06600	PHYSICAL THERAPY	3,145	0	0	0	4,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	609	0	0	0	528	67.00
68.00	06800	SPEECH PATHOLOGY	1,116	0	0	0	566	68.00
69.00	06900	ELECTROCARDIOLOGY	2,739	0	0	0	1,729	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,116	0	0	0	1,254	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	134,321	0	6,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	238,794	0	6,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	146,809	21,893	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,522	0	0	0	22	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	67	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	97	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	158	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	138	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	328	88.04
91.00	09100	EMERGENCY	9,232	29,726	0	0	12,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,522	0	0	0	1,004	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	609	0	0	0	1,216	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,050	197,198	373,115	146,809	178,373	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,277	0	0	0	0	192.00
194.00	07950	WELLNESS	1,420	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	1,015	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	507	0	0	0	0	194.05
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)	123,269	197,198	373,115	146,809	178,373	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,493,068	0	2,493,068		30.00
32.00	03200	CORONARY CARE UNIT	343,437	0	343,437		32.00
40.00	04000	SUBPROVIDER - IPF	286,771	0	286,771		40.00
43.00	04300	NURSERY	93,690	0	93,690		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,603,855	0	2,603,855		50.00
51.00	05100	RECOVERY ROOM	282,587	0	282,587		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,963	0	102,963		52.00
53.00	05300	ANESTHESIOLOGY	170,170	0	170,170		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,102,679	0	1,102,679		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,303,909	0	1,303,909		55.00
56.00	05600	RADIOISOTOPE	757,210	0	757,210		56.00
57.00	05700	CT SCAN	155,791	0	155,791		57.00
58.00	05800	MRI	84,419	0	84,419		58.00
59.00	05900	CARDIAC CATHETERIZATION	391,109	0	391,109		59.00
60.00	06000	LABORATORY	938,668	0	938,668		60.00
65.00	06500	RESPIRATORY THERAPY	146,870	0	146,870		65.00
66.00	06600	PHYSICAL THERAPY	396,347	0	396,347		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,874	0	32,874		67.00
68.00	06800	SPEECH PATHOLOGY	101,359	0	101,359		68.00
69.00	06900	ELECTROCARDIOLOGY	268,432	0	268,432		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,687	0	169,687		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,225	0	248,225		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,981	0	458,981		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	617,978	0	617,978		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	70,560	0	70,560		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	243,915	0	243,915		88.00
88.01	08801	RURAL HEALTH CLINIC II	129,102	0	129,102		88.01
88.02	08802	RURAL HEALTH CLINIC III	82,414	0	82,414		88.02
88.03	08803	RURAL HEALTH CLINIC IV	86,884	0	86,884		88.03
88.04	08805	RURAL HEALTH CLINIC V	225,866	0	225,866		88.04
91.00	09100	EMERGENCY	695,558	0	695,558		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	258,640	0	258,640		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	111,207	0	111,207		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,455,225	0	15,455,225		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,710,965	0	3,710,965		192.00
194.00	07950	WELLNESS	481,676	0	481,676		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	223,507	0	223,507		194.01
194.02	07951	LIFELINE	7,074	0	7,074		194.02
194.03	07952	OCCUPATIONAL HEALTH	76,971	0	76,971		194.03
194.05	07954	MISC. NONREIMBURSABLE	427,693	0	427,693		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	20,383,111	0	20,383,111		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	533,439					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,681,256				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,658	2,840	146,257,877			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,869	4,798,407	15,485,601	-43,901,468	222,976,780	5.00
7.00	00700	OPERATION OF PLANT	33,754	517,793	1,320,128	0	6,454,248	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	0	31,772	0	627,093	8.00
9.00	00900	HOUSEKEEPING	1,004	18,890	1,652,169	0	2,555,035	9.00
10.00	01000	DIETARY	6,564	39,700	397,899	0	970,629	10.00
11.00	01100	CAFETERIA	3,973	16,074	1,137,206	0	1,446,034	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	72,670	1,874,939	0	2,782,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	186,410	599,218	0	1,937,568	14.00
15.00	01500	PHARMACY	2,935	24,604	1,699,730	0	2,535,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	38,546	1,643,026	0	2,514,200	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,917	682,771	16,711,983	0	20,012,272	30.00
32.00	03200	CORONARY CARE UNIT	4,908	127,738	1,727,686	0	3,444,496	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	19,431	3,908,508	0	3,127,140	40.00
43.00	04300	NURSERY	617	50,660	502,542	0	703,070	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,537	1,366,986	5,894,345	0	12,127,921	50.00
51.00	05100	RECOVERY ROOM	8,502	63,447	1,379,176	0	2,136,643	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	36,654	762,638	0	1,067,768	52.00
53.00	05300	ANESTHESIOLOGY	646	89,599	5,190,703	0	1,771,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,133	580,981	6,887,995	0	6,300,774	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	28,342	646,306	2,535,353	0	3,659,159	55.00
56.00	05600	RADIOISOTOPE	1,948	521,001	1,432,725	0	3,808,386	56.00
57.00	05700	CT SCAN	1,526	68,021	543,271	0	1,317,498	57.00
58.00	05800	MRI	2,043	12,566	443,914	0	1,145,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	249,120	741,345	0	1,749,084	59.00
60.00	06000	LABORATORY	12,282	348,406	5,179,604	0	11,452,130	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	58,554	1,137,917	0	1,770,193	65.00
66.00	06600	PHYSICAL THERAPY	14,378	30,240	2,598,683	0	4,632,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	4,171	526,135	0	715,637	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	26,303	814,846	0	750,150	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	93,612	1,493,398	0	2,238,776	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	23,661	1,393,987	0	2,441,555	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,887,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,710,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,200,638	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	2,766	645,868	0	867,192	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,254	18,177	322,989	0	725,297	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,613	6,950	392,139	0	713,061	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,591	9,750	744,553	0	1,119,245	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,935	16,144	488,334	0	825,190	88.03
88.04	08805	RURAL HEALTH CLINIC V	8,456	36,927	1,199,164	0	1,904,977	88.04
91.00	09100	EMERGENCY	17,842	93,969	9,286,951	0	8,497,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	31,512	3,885,975	0	5,633,842	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	491	1,639,735	0	3,066,503	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	380,099	11,032,848	106,254,150	-43,901,468	159,347,310	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,251	413,146	35,804,722	0	54,421,451	192.00
194.00	07950	WELLNESS	23,300	69,754	564,875	0	1,417,297	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	104,601	1,348,188	0	3,630,671	194.01
194.02	07951	LIFELINE	240	0	15,333	0	122,751	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	4,841	704,154	0	895,326	194.03
194.05	07954	MISC. NONREIMBURSABLE	17,638	56,066	1,566,455	0	3,141,974	194.05
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)	6,718,124	13,664,987	32,235,227		43,901,468	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.593987	1.169822	0.220400		0.196888	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			49,391		6,183,593	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000338		0.027732	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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		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
7.00	00700	OPERATION OF PLANT	452,613					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,085,612				8.00
9.00	00900	HOUSEKEEPING	1,004	50,330	11,306			9.00
10.00	01000	DIETARY	6,564	14,781	0	156,312		10.00
11.00	01100	CAFETERIA	3,973	0	340	0	1,215	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	0	88	0	27	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	20,727	128	0	18	14.00
15.00	01500	PHARMACY	2,935	0	20	0	21	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	0	52	0	36	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,917	306,027	94	124,154	264	30.00
32.00	03200	CORONARY CARE UNIT	4,908	25,528	224	5,222	28	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	28,940	330	21,674	32	40.00
43.00	04300	NURSERY	617	8,263	0	0	9	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,537	172,000	3,113	790	75	50.00
51.00	05100	RECOVERY ROOM	8,502	69,142	320	0	23	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	23,822	0	0	13	52.00
53.00	05300	ANESTHESIOLOGY	646	0	20	0	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,133	51,636	193	0	42	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	28,342	0	800	0	23	55.00
56.00	05600	RADIOISOTOPE	1,948	31,311	80	0	17	56.00
57.00	05700	CT SCAN	1,526	20,114	48	0	9	57.00
58.00	05800	MRI	2,043	8,116	20	0	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	21,451	100	0	8	59.00
60.00	06000	LABORATORY	12,282	385	425	0	95	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	68	0	21	65.00
66.00	06600	PHYSICAL THERAPY	14,378	9,006	420	0	31	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	0	40	0	6	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	114	60	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	11,265	408	0	27	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	1,124	136	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	0	0	15	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,254	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,613	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,591	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,935	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	8,456	0	0	0	0	88.04
91.00	09100	EMERGENCY	17,842	211,524	1,207	4,472	91	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	0	80	0	15	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	0	32	0	6	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,818	1,085,606	8,846	156,312	996	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,956	6	1,760	0	190	192.00
194.00	07950	WELLNESS	23,300	0	350	0	14	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	240	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	0	80	0	10	194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	0	270	0	5	194.05
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)	7,725,012	768,686	3,110,864	1,284,232	1,892,103	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.067588	0.708067	275.151601	8.215825	1,557.286420	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,210,258	33,617	110,400	174,170	123,269	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.673936	0.030966	9.764727	1.114246	101.455967	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	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
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	962,924					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	956,148,371		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	453,446	0	0	227,635,959		30.00
32.00	03200	CORONARY CARE UNIT	51,832	0	0	3,801,360		32.00
40.00	04000	SUBPROVIDER - IPF	49,559	0	0	6,639,574		40.00
43.00	04300	NURSERY	18,853	0	0	1,650,255		43.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174,181	0	0	71,678,812		50.00
51.00	05100	RECOVERY ROOM	41,927	0	0	14,186,827		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,303	0	0	5,804,634		52.00
53.00	05300	ANESTHESIOLOGY	670	0	0	14,673,191		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,392,239		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,141,312		55.00
56.00	05600	RADIOISOTOPE	0	0	0	45,005,310		56.00
57.00	05700	CT SCAN	0	0	0	75,907,363		57.00
58.00	05800	MRI	0	0	0	29,085,271		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,179,693		59.00
60.00	06000	LABORATORY	0	0	0	55,796,402		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,435,419		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,445,387		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,824,129		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,024,971		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,245,914		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,704,683		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	36	0	32,574,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64	0	34,003,770		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	117,075,152		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	115,665		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	358,160		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	519,878		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	844,169		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	736,543		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	1,755,104		88.04
91.00	09100	EMERGENCY	145,153	0	0	65,034,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	5,369,363		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	6,502,608		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	962,924	100	100	956,148,371		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	WELLNESS	0	0	0	0		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0		194.01
194.02	07951	LIFELINE	0	0	0	0		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	0	0	0		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	0	0	0		194.05
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)	3,430,834	2,505,852	3,123,032	3,145,364		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.562933	25,058.520000	31,230.320000	0.003290		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	197,198	373,115	146,809	178,373		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 2:31 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.204791	3,731.150000	1,468.090000	0.000187		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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Hospital | PPS

		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	28,910,543		28,910,543	0	28,910,543	30.00
32.00	03200	CORONARY CARE UNIT	4,569,841		4,569,841	0	4,569,841	32.00
40.00	04000	SUBPROVIDER - IPF	4,429,227		4,429,227	0	4,429,227	40.00
43.00	04300	NURSERY	944,495		944,495	0	944,495	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,114,470		17,114,470	0	17,114,470	50.00
51.00	05100	RECOVERY ROOM	3,071,313		3,071,313	0	3,071,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,455,502		1,455,502	0	1,455,502	52.00
53.00	05300	ANESTHESIOLOGY	2,211,379		2,211,379	0	2,211,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,080,987		8,080,987	0	8,080,987	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,165,797		5,165,797	0	5,165,797	55.00
56.00	05600	RADIOISOTOPE	4,810,183		4,810,183	0	4,810,183	56.00
57.00	05700	CT SCAN	1,894,143		1,894,143	0	1,894,143	57.00
58.00	05800	MRI	1,524,334		1,524,334	0	1,524,334	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,286,547		2,286,547	0	2,286,547	59.00
60.00	06000	LABORATORY	14,365,265		14,365,265	14,498	14,379,763	60.00
65.00	06500	RESPIRATORY THERAPY	2,240,708	0	2,240,708	0	2,240,708	65.00
66.00	06600	PHYSICAL THERAPY	6,040,930	0	6,040,930	0	6,040,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	893,381	0	893,381	0	893,381	67.00
68.00	06800	SPEECH PATHOLOGY	994,325	0	994,325	0	994,325	68.00
69.00	06900	ELECTROCARDIOLOGY	2,970,116		2,970,116	0	2,970,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,078,030		3,078,030	0	3,078,030	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,662,341		5,662,341	0	5,662,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,944,243		10,944,243	0	10,944,243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,898,558		22,898,558	0	22,898,558	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,108,079		1,108,079	0	1,108,079	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,095,491		1,095,491	0	1,095,491	88.00
88.01	08801	RURAL HEALTH CLINIC II	968,032		968,032	0	968,032	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,386,610		1,386,610	0	1,386,610	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,040,176		1,040,176	0	1,040,176	88.03
88.04	08805	RURAL HEALTH CLINIC V	2,430,142		2,430,142	0	2,430,142	88.04
91.00	09100	EMERGENCY	11,866,178		11,866,178	0	11,866,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,834,529		6,834,529		6,834,529	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,874,214		6,874,214		6,874,214	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,735,405		3,735,405		3,735,405	116.00
200.00		Subtotal (see instructions)	193,895,514	0	193,895,514	14,498	193,910,012	200.00
201.00		Less Observation Beds	6,834,529		6,834,529		6,834,529	201.00
202.00		Total (see instructions)	187,060,985	0	187,060,985	14,498	187,075,483	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Hospital | PPS

		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	221,593,576		221,593,576			30.00
32.00	03200	CORONARY CARE UNIT	3,801,360		3,801,360			32.00
40.00	04000	SUBPROVIDER - IPF	6,639,574		6,639,574			40.00
43.00	04300	NURSERY	1,650,255		1,650,255			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,880,403	52,798,409	71,678,812	0.238766	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,914,069	10,272,758	14,186,827	0.216490	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,452,763	351,871	5,804,634	0.250748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,858,511	8,814,680	14,673,191	0.150709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,728,817	33,663,422	38,392,239	0.210485	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,304	14,074,008	14,141,312	0.365298	0.000000	55.00
56.00	05600	RADIOISOTOPE	6,977,158	38,028,152	45,005,310	0.106880	0.000000	56.00
57.00	05700	CT SCAN	14,115,989	61,791,374	75,907,363	0.024953	0.000000	57.00
58.00	05800	MRI	2,059,093	27,026,178	29,085,271	0.052409	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,762,636	18,417,057	27,179,693	0.084127	0.000000	59.00
60.00	06000	LABORATORY	10,299,403	45,496,999	55,796,402	0.257459	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,482,823	1,952,596	13,435,419	0.166776	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,085,197	22,360,190	24,445,387	0.247119	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	656,946	2,167,183	2,824,129	0.316339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	345,399	2,679,572	3,024,971	0.328706	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,758,912	7,487,002	9,245,914	0.321236	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	266,096	6,438,587	6,704,683	0.459087	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,019,351	22,555,585	32,574,936	0.173825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,263,381	7,740,389	34,003,770	0.321854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,015,425	90,059,727	117,075,152	0.195589	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	115,665	115,665	9.580072	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	358,160	358,160			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	519,878	519,878			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	844,169	844,169			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	736,543	736,543			88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,755,104	1,755,104			88.04
91.00	09100	EMERGENCY	13,363,889	51,670,429	65,034,318	0.182460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,042,383	6,042,383	1.131098	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,369,363	5,369,363			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	6,502,608	6,502,608			116.00
200.00		Subtotal (see instructions)	408,058,330	548,090,041	956,148,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	408,058,330	548,090,041	956,148,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
32.00	03200	CORONARY CARE UNIT			32.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.238766		50.00
51.00	05100	RECOVERY ROOM	0.216490		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250748		52.00
53.00	05300	ANESTHESIOLOGY	0.150709		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210485		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365298		55.00
56.00	05600	RADIOISOTOPE	0.106880		56.00
57.00	05700	CT SCAN	0.024953		57.00
58.00	05800	MRI	0.052409		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084127		59.00
60.00	06000	LABORATORY	0.257718		60.00
65.00	06500	RESPIRATORY THERAPY	0.166776		65.00
66.00	06600	PHYSICAL THERAPY	0.247119		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316339		67.00
68.00	06800	SPEECH PATHOLOGY	0.328706		68.00
69.00	06900	ELECTROCARDIOLOGY	0.321236		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.459087		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173825		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.321854		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195589		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9.580072		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08805	RURAL HEALTH CLINIC V			88.04
91.00	09100	EMERGENCY	0.182460		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.131098		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,910,543		28,910,543	0	28,910,543	30.00
32.00	03200	CORONARY CARE UNIT	4,569,841		4,569,841	0	4,569,841	32.00
40.00	04000	SUBPROVIDER - IPF	4,429,227		4,429,227	0	4,429,227	40.00
43.00	04300	NURSERY	944,495		944,495	0	944,495	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,114,470		17,114,470	0	17,114,470	50.00
51.00	05100	RECOVERY ROOM	3,071,313		3,071,313	0	3,071,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,455,502		1,455,502	0	1,455,502	52.00
53.00	05300	ANESTHESIOLOGY	2,211,379		2,211,379	0	2,211,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,080,987		8,080,987	0	8,080,987	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,165,797		5,165,797	0	5,165,797	55.00
56.00	05600	RADIOISOTOPE	4,810,183		4,810,183	0	4,810,183	56.00
57.00	05700	CT SCAN	1,894,143		1,894,143	0	1,894,143	57.00
58.00	05800	MRI	1,524,334		1,524,334	0	1,524,334	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,286,547		2,286,547	0	2,286,547	59.00
60.00	06000	LABORATORY	14,365,265		14,365,265	14,498	14,379,763	60.00
65.00	06500	RESPIRATORY THERAPY	2,240,708	0	2,240,708	0	2,240,708	65.00
66.00	06600	PHYSICAL THERAPY	6,040,930	0	6,040,930	0	6,040,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	893,381	0	893,381	0	893,381	67.00
68.00	06800	SPEECH PATHOLOGY	994,325	0	994,325	0	994,325	68.00
69.00	06900	ELECTROCARDIOLOGY	2,970,116		2,970,116	0	2,970,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,078,030		3,078,030	0	3,078,030	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,662,341		5,662,341	0	5,662,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,944,243		10,944,243	0	10,944,243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,898,558		22,898,558	0	22,898,558	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,108,079		1,108,079	0	1,108,079	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,095,491		1,095,491	0	1,095,491	88.00
88.01	08801	RURAL HEALTH CLINIC II	968,032		968,032	0	968,032	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,386,610		1,386,610	0	1,386,610	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,040,176		1,040,176	0	1,040,176	88.03
88.04	08805	RURAL HEALTH CLINIC V	2,430,142		2,430,142	0	2,430,142	88.04
91.00	09100	EMERGENCY	11,866,178		11,866,178	0	11,866,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,834,529		6,834,529		6,834,529	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,874,214		6,874,214		6,874,214	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,735,405		3,735,405		3,735,405	116.00
200.00		Subtotal (see instructions)	193,895,514	0	193,895,514	14,498	193,910,012	200.00
201.00		Less Observation Beds	6,834,529		6,834,529		6,834,529	201.00
202.00		Total (see instructions)	187,060,985	0	187,060,985	14,498	187,075,483	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/26/2018 2:31 pm

Title XIX | Hospital | Cost

		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	221,593,576		221,593,576			30.00
32.00	03200	CORONARY CARE UNIT	3,801,360		3,801,360			32.00
40.00	04000	SUBPROVIDER - IPF	6,639,574		6,639,574			40.00
43.00	04300	NURSERY	1,650,255		1,650,255			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,880,403	52,798,409	71,678,812	0.238766	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,914,069	10,272,758	14,186,827	0.216490	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,452,763	351,871	5,804,634	0.250748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,858,511	8,814,680	14,673,191	0.150709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,728,817	33,663,422	38,392,239	0.210485	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,304	14,074,008	14,141,312	0.365298	0.000000	55.00
56.00	05600	RADIOISOTOPE	6,977,158	38,028,152	45,005,310	0.106880	0.000000	56.00
57.00	05700	CT SCAN	14,115,989	61,791,374	75,907,363	0.024953	0.000000	57.00
58.00	05800	MRI	2,059,093	27,026,178	29,085,271	0.052409	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,762,636	18,417,057	27,179,693	0.084127	0.000000	59.00
60.00	06000	LABORATORY	10,299,403	45,496,999	55,796,402	0.257459	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,482,823	1,952,596	13,435,419	0.166776	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,085,197	22,360,190	24,445,387	0.247119	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	656,946	2,167,183	2,824,129	0.316339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	345,399	2,679,572	3,024,971	0.328706	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,758,912	7,487,002	9,245,914	0.321236	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	266,096	6,438,587	6,704,683	0.459087	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,019,351	22,555,585	32,574,936	0.173825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,263,381	7,740,389	34,003,770	0.321854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,015,425	90,059,727	117,075,152	0.195589	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	115,665	115,665	9.580072	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	358,160	358,160	3.058664	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	519,878	519,878	1.862037	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	844,169	844,169	1.642574	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	736,543	736,543	1.412241	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,755,104	1,755,104	1.384614	0.000000	88.04
91.00	09100	EMERGENCY	13,363,889	51,670,429	65,034,318	0.182460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,042,383	6,042,383	1.131098	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,369,363	5,369,363			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	6,502,608	6,502,608			116.00
200.00		Subtotal (see instructions)	408,058,330	548,090,041	956,148,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	408,058,330	548,090,041	956,148,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
32.00	03200	CORONARY CARE UNIT			32.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		88.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/26/2018 2:31 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	2,493,068	0	2,493,068	21,235	117.40	30.00
32.00	CORONARY CARE UNIT	343,437		343,437	1,931	177.85	32.00
40.00	SUBPROVIDER - IPF	286,771	0	286,771	5,095	56.28	40.00
43.00	NURSERY	93,690		93,690	1,167	80.28	43.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	3,216,966		3,216,966	29,428		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	8,583	1,007,644	30.00
32.00	CORONARY CARE UNIT	1,058	188,165	32.00
40.00	SUBPROVIDER - IPF	1,771	99,672	40.00
43.00	NURSERY	0	0	43.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	11,412	1,295,481	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 2:31 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,603,855	71,678,812	0.036327	9,511,058	345,508	50.00
51.00	05100	RECOVERY ROOM	282,587	14,186,827	0.019919	1,647,116	32,809	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,963	5,804,634	0.017738	20,430	362	52.00
53.00	05300	ANESTHESIOLOGY	170,170	14,673,191	0.011597	2,381,423	27,617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,102,679	38,392,239	0.028721	2,447,859	70,305	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,303,909	14,141,312	0.092206	45,079	4,157	55.00
56.00	05600	RADIOISOTOPE	757,210	45,005,310	0.016825	3,511,236	59,077	56.00
57.00	05700	CT SCAN	155,791	75,907,363	0.002052	7,361,719	15,106	57.00
58.00	05800	MRI	84,419	29,085,271	0.002902	1,130,018	3,279	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,109	27,179,693	0.014390	2,981,758	42,907	59.00
60.00	06000	LABORATORY	938,668	55,796,402	0.016823	5,255,504	88,413	60.00
65.00	06500	RESPIRATORY THERAPY	146,870	13,435,419	0.010932	6,524,390	71,325	65.00
66.00	06600	PHYSICAL THERAPY	396,347	24,445,387	0.016214	1,167,926	18,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,874	2,824,129	0.011640	377,945	4,399	67.00
68.00	06800	SPEECH PATHOLOGY	101,359	3,024,971	0.033507	179,717	6,022	68.00
69.00	06900	ELECTROCARDIOLOGY	268,432	9,245,914	0.029033	977,351	28,375	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,687	6,704,683	0.025309	129,699	3,283	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,225	32,574,936	0.007620	5,376,367	40,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,981	34,003,770	0.013498	10,379,971	140,109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	617,978	117,075,152	0.005278	13,187,003	69,601	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	70,560	115,665	0.610038	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	243,915	358,160	0.681022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	129,102	519,878	0.248331	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	82,414	844,169	0.097627	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	86,884	736,543	0.117962	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	225,866	1,755,104	0.128691	0	0	88.04
91.00	09100	EMERGENCY	695,558	65,034,318	0.010695	7,369,510	78,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	589,369	6,042,383	0.097539	0	0	92.00
200.00		Total (lines 50 through 199)	12,457,781	710,591,635		81,963,079	1,151,376	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 2:31 pm

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		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
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
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	21,235	0.00	8,583	30.00
32.00	03200	CORONARY CARE UNIT		0	1,931	0.00	1,058	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,095	0.00	1,771	40.00
43.00	04300	NURSERY		0	1,167	0.00	0	43.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	29,428		11,412	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
32.00	03200	CORONARY CARE UNIT	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 2:31 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:31 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	71,678,812	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,186,827	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,804,634	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,673,191	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,392,239	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,141,312	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	45,005,310	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,907,363	0.000000	57.00
58.00	05800	MRI	0	0	0	29,085,271	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,179,693	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	55,796,402	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,435,419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,445,387	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,824,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,024,971	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,245,914	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,704,683	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,574,936	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,003,770	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,075,152	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	115,665	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	358,160	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	519,878	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	844,169	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	736,543	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	1,755,104	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	65,034,318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,042,383	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	710,591,635		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 2:31 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	9,511,058	0	22,422,086	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,647,116	0	2,170,321	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	20,430	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,381,423	0	3,150,930	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,447,859	0	12,796,057	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	45,079	0	5,189,383	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	3,511,236	0	10,136,258	0	56.00
57.00	05700	CT SCAN	0.000000	7,361,719	0	18,665,810	0	57.00
58.00	05800	MRI	0.000000	1,130,018	0	8,255,670	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,981,758	0	6,984,064	0	59.00
60.00	06000	LABORATORY	0.000000	5,255,504	0	4,769,355	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,524,390	0	640,312	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,167,926	0	409,437	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	377,945	0	46,751	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	179,717	0	306,170	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	977,351	0	2,478,030	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	129,699	0	548,906	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,376,367	0	5,407,168	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,379,971	0	3,294,111	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,187,003	0	42,186,780	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	7,369,510	0	13,591,343	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	2,672,403	0	92.00
200.00		Total (lines 50 through 199)		81,963,079	0	166,121,345	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 2:31 pm

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		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	0.238766	22,422,086	0	0	5,353,632	50.00
51.00	05100	RECOVERY ROOM	0.216490	2,170,321	0	0	469,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.150709	3,150,930	714	0	474,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210485	12,796,057	413	0	2,693,378	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365298	5,189,383	0	0	1,895,671	55.00
56.00	05600	RADIOISOTOPE	0.106880	10,136,258	0	0	1,083,363	56.00
57.00	05700	CT SCAN	0.024953	18,665,810	6,057	0	465,768	57.00
58.00	05800	MRI	0.052409	8,255,670	0	0	432,671	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084127	6,984,064	0	0	587,548	59.00
60.00	06000	LABORATORY	0.257459	4,769,355	6,026	0	1,227,913	60.00
65.00	06500	RESPIRATORY THERAPY	0.166776	640,312	578	0	106,789	65.00
66.00	06600	PHYSICAL THERAPY	0.247119	409,437	0	0	101,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316339	46,751	0	0	14,789	67.00
68.00	06800	SPEECH PATHOLOGY	0.328706	306,170	287	0	100,640	68.00
69.00	06900	ELECTROCARDIOLOGY	0.321236	2,478,030	572	0	796,032	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.459087	548,906	0	0	251,996	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173825	5,407,168	0	0	939,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.321854	3,294,111	84	0	1,060,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195589	42,186,780	705	156,254	8,251,270	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9.580072	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.182460	13,591,343	3,340	0	2,479,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.131098	2,672,403	1,586	0	3,022,750	92.00
200.00		Subtotal (see instructions)		166,121,345	20,362	156,254	31,810,117	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		166,121,345	20,362	156,254	31,810,117	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 2:31 pm

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		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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	108	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	151	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,551	0		60.00
65.00	06500	RESPIRATORY THERAPY	96	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	94	0		68.00
69.00	06900	ELECTROCARDIOLOGY	184	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138	30,562		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	609	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,794	0		92.00
200.00		Subtotal (see instructions)	4,839	30,562		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,839	30,562		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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	2,603,855	71,678,812	0.036327	1,262	46	50.00
51.00	05100	RECOVERY ROOM	282,587	14,186,827	0.019919	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,963	5,804,634	0.017738	0	0	52.00
53.00	05300	ANESTHESIOLOGY	170,170	14,673,191	0.011597	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,102,679	38,392,239	0.028721	48,856	1,403	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,303,909	14,141,312	0.092206	0	0	55.00
56.00	05600	RADIOISOTOPE	757,210	45,005,310	0.016825	19,671	331	56.00
57.00	05700	CT SCAN	155,791	75,907,363	0.002052	164,375	337	57.00
58.00	05800	MRI	84,419	29,085,271	0.002902	84,404	245	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,109	27,179,693	0.014390	0	0	59.00
60.00	06000	LABORATORY	938,668	55,796,402	0.016823	278,338	4,682	60.00
65.00	06500	RESPIRATORY THERAPY	146,870	13,435,419	0.010932	192,137	2,100	65.00
66.00	06600	PHYSICAL THERAPY	396,347	24,445,387	0.016214	16,190	263	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,874	2,824,129	0.011640	3,500	41	67.00
68.00	06800	SPEECH PATHOLOGY	101,359	3,024,971	0.033507	4,022	135	68.00
69.00	06900	ELECTROCARDIOLOGY	268,432	9,245,914	0.029033	33,953	986	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,687	6,704,683	0.025309	15,301	387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	248,225	32,574,936	0.007620	14,688	112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,981	34,003,770	0.013498	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	617,978	117,075,152	0.005278	270,533	1,428	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	70,560	115,665	0.610038	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	243,915	358,160	0.681022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	129,102	519,878	0.248331	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	82,414	844,169	0.097627	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	86,884	736,543	0.117962	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	225,866	1,755,104	0.128691	0	0	88.04
91.00	09100	EMERGENCY	695,558	65,034,318	0.010695	452,338	4,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,042,383	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	11,868,412	710,591,635		1,599,568	17,334	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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	71,678,812	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,186,827	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,804,634	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,673,191	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,392,239	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,141,312	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	45,005,310	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,907,363	0.000000	57.00
58.00	05800	MRI	0	0	0	29,085,271	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	27,179,693	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	55,796,402	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,435,419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,445,387	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,824,129	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,024,971	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,245,914	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,704,683	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,574,936	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,003,770	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,075,152	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	115,665	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	358,160	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	519,878	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	844,169	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	736,543	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	1,755,104	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	65,034,318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,042,383	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	710,591,635		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | PPS

		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	1,262	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	48,856	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	19,671	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	164,375	0	0	0	57.00
58.00	05800	MRI	0.000000	84,404	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	278,338	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	192,137	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	16,190	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,500	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,022	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	33,953	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	15,301	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	14,688	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	270,533	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	452,338	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,599,568	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:31 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)	21,235	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,235	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)	16,215	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,583	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	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)	28,910,543	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)	28,910,543	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)	28,910,543	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)	1,361.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,685,411	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)	11,685,411	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:31 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT	4,569,841	1,931	2,366.57	1,058	2,503,831	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)	15,874,837	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	30,064,079	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)	1,195,809	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,151,376	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,347,185	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	27,716,894	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)	5,020	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,361.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,834,529	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:31 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	2,493,068	28,910,543	0.086234	6,834,529	589,369	90.00
91.00	Nursing School cost	0	28,910,543	0.000000	6,834,529	0	91.00
92.00	Allied health cost	0	28,910,543	0.000000	6,834,529	0	92.00
93.00	All other Medical Education	0	28,910,543	0.000000	6,834,529	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Subprovider - IPF	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)	5,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,095	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)	5,095	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,771	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	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)	4,429,227	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)	4,429,227	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)	4,429,227	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)	869.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,539,583	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,539,583	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	287,350	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,826,933	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)	99,672	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,334	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	117,006	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,709,927	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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	286,771	4,429,227	0.064745	0	0	90.00
91.00	Nursing School cost	0	4,429,227	0.000000	0	0	91.00
92.00	Allied health cost	0	4,429,227	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,429,227	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:31 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		10,495,055		30.00
32.00	03200	CORONARY CARE UNIT		2,080,428		32.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.238766	9,511,058	2,270,917	50.00
51.00	05100	RECOVERY ROOM	0.216490	1,647,116	356,584	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250748	20,430	5,123	52.00
53.00	05300	ANESTHESIOLOGY	0.150709	2,381,423	358,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210485	2,447,859	515,238	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365298	45,079	16,467	55.00
56.00	05600	RADIOISOTOPE	0.106880	3,511,236	375,281	56.00
57.00	05700	CT SCAN	0.024953	7,361,719	183,697	57.00
58.00	05800	MRI	0.052409	1,130,018	59,223	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084127	2,981,758	250,846	59.00
60.00	06000	LABORATORY	0.257718	5,255,504	1,354,438	60.00
65.00	06500	RESPIRATORY THERAPY	0.166776	6,524,390	1,088,112	65.00
66.00	06600	PHYSICAL THERAPY	0.247119	1,167,926	288,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316339	377,945	119,559	67.00
68.00	06800	SPEECH PATHOLOGY	0.328706	179,717	59,074	68.00
69.00	06900	ELECTROCARDIOLOGY	0.321236	977,351	313,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.459087	129,699	59,543	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173825	5,376,367	934,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.321854	10,379,971	3,340,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195589	13,187,003	2,579,233	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9.580072	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.182460	7,369,510	1,344,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.131098	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		81,963,079	15,874,837	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)		81,963,079		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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
32.00	03200	CORONARY CARE UNIT		0		32.00
40.00	04000	SUBPROVIDER - IPF		2,267,017		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.238766	1,262	301	50.00
51.00	05100	RECOVERY ROOM	0.216490	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250748	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.150709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210485	48,856	10,283	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365298	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106880	19,671	2,102	56.00
57.00	05700	CT SCAN	0.024953	164,375	4,102	57.00
58.00	05800	MRI	0.052409	84,404	4,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084127	0	0	59.00
60.00	06000	LABORATORY	0.257718	278,338	71,733	60.00
65.00	06500	RESPIRATORY THERAPY	0.166776	192,137	32,044	65.00
66.00	06600	PHYSICAL THERAPY	0.247119	16,190	4,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.316339	3,500	1,107	67.00
68.00	06800	SPEECH PATHOLOGY	0.328706	4,022	1,322	68.00
69.00	06900	ELECTROCARDIOLOGY	0.321236	33,953	10,907	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.459087	15,301	7,024	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173825	14,688	2,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.321854	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195589	270,533	52,913	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9.580072	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.182460	452,338	82,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.131098	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,599,568	287,350	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,599,568		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 2:31 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)	4,612,644	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	15,293,288	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)	482,608	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)	72.25	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)	4.96	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.38	31.00
32.00	Sum of lines 30 and 31	25.34	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.12	33.00
34.00	Disproportionate share adjustment (see instructions)	503,620	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 2:31 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)	0.000107480	0.000106832	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	642,460	722,900	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	161,935	540,689	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	702,624		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)	21,594,784		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	23,886,884		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		23,886,884	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,631,916	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		3,252	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)		25,522,052	59.00
60.00	Primary payer payments		2,141	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,519,911	61.00
62.00	Deductibles billed to program beneficiaries		2,749,556	62.00
63.00	Coinsurance billed to program beneficiaries		21,888	63.00
64.00	Allowable bad debts (see instructions)		580,011	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		377,007	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		580,011	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,125,474	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)		89,671	70.93
70.94	HRR adjustment amount (see instructions)		-103,767	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Hospital	PPS

		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)	0	0	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)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		258,789	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,852,589	71.00
71.01	Sequestration adjustment (see instructions)		457,052	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		22,564,600	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)		-169,063	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		129,508	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	35,401	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31,810,117	2.00
3.00	OPPS payments	26,362,716	3.00
4.00	Outlier payment (see instructions)	206,355	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)	35,401	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	176,616	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)	176,616	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)	176,616	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	141,215	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)	35,401	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)	26,569,071	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)	5,155,511	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)	21,448,961	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)	21,448,961	30.00
31.00	Primary payer payments	580	31.00
32.00	Subtotal (line 30 minus line 31)	21,448,381	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)	1,061,424	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	689,926	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,061,424	36.00
37.00	Subtotal (see instructions)	22,138,307	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)	22,138,307	40.00
40.01	Sequestration adjustment (see instructions)	442,766	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	21,275,704	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	419,837	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: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 2:31 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		22,766,098		21,334,871	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	01/11/2018	201,498	01/11/2018	59,167	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)		-201,498		-59,167	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)		22,564,600		21,275,704	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		419,837	6.01
6.02	SETTLEMENT TO PROGRAM		169,063		0	6.02
7.00	Total Medicare program liability (see instructions)		22,395,537		21,695,541	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: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Subprovider - IPF | 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		1,377,699		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)		1,377,699		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		72,200		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,449,899		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,635,582	1.00
2.00	Net IPF PPS Outlier Payments	6,185	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	13.958904	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,641,767	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,641,767	16.00
17.00	Primary payer payments	1,896	17.00
18.00	Subtotal (line 16 less line 17).	1,639,871	18.00
19.00	Deductibles	173,788	19.00
20.00	Subtotal (line 18 minus line 19)	1,466,083	20.00
21.00	Coinsurance	60,214	21.00
22.00	Subtotal (line 20 minus line 21)	1,405,869	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	113,261	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	73,620	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	113,261	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,479,489	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,479,489	31.00
31.01	Sequestration adjustment (see instructions)	29,590	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,377,699	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	72,200	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	6,185	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 2:31 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	43,640,747	0	0	0	1.00
2.00	Temporary investments	19,101,391	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	130,615,140	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-74,751,405	0	0	0	6.00
7.00	Inventory	5,094,073	0	0	0	7.00
8.00	Prepaid expenses	6,034,315	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	129,734,261	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,677,396	0	0	0	12.00
13.00	Land improvements	14,062,953	0	0	0	13.00
14.00	Accumulated depreciation	-5,571,287	0	0	0	14.00
15.00	Buildings	196,471,425	0	0	0	15.00
16.00	Accumulated depreciation	-57,000,168	0	0	0	16.00
17.00	Leasehold improvements	270,012	0	0	0	17.00
18.00	Accumulated depreciation	-229,582	0	0	0	18.00
19.00	Fixed equipment	18,849,298	0	0	0	19.00
20.00	Accumulated depreciation	-12,769,711	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	120,048,752	0	0	0	23.00
24.00	Accumulated depreciation	-74,325,538	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	203,483,550	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	183,659,514	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	83,053,318	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	266,712,832	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	599,930,643	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,458,446	0	0	0	37.00
38.00	Salaries, wages, and fees payable	24,823,590	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,108,417	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	12,384,485	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	53,774,938	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	131,133,577	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	131,133,577	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	184,908,515	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	415,022,128				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)	415,022,128	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	599,930,643	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 2:31 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		363,701,968		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		51,320,160				2.00
3.00	Total (sum of line 1 and line 2)		415,022,128		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)		415,022,128		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		415,022,128		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/26/2018 2:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,593,576		21,593,576	1.00
2.00	SUBPROVIDER - IPF	6,639,574		6,639,574	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	28,233,150		28,233,150	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	3,801,360		3,801,360	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)	3,801,360		3,801,360	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,034,510		32,034,510	17.00
18.00	Ancillary services	174,366,622	480,220,466	654,587,088	18.00
19.00	Outpatient services	0	51,669,853	51,669,853	19.00
20.00	RURAL HEALTH CLINIC	0	358,160	358,160	20.00
20.01	RURAL HEALTH CLINIC II	0	519,878	519,878	20.01
20.02	RURAL HEALTH CLINIC III	0	844,169	844,169	20.02
20.03	RURAL HEALTH CLINIC IV	0	736,543	736,543	20.03
20.04	RURAL HEALTH CLINIC V	0	1,755,104	1,755,104	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,369,363	5,369,363	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	0	6,502,608	6,502,608	26.00
27.00	OTHER: NURS IP, HMKRS, ACCRL, OCC HT	1,649,076	428,875	2,077,951	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	208,050,208	548,405,019	756,455,227	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		305,971,608		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)		305,971,608		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/26/2018 2:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	756,455,227	1.00
2.00	Less contractual allowances and discounts on patients' accounts	484,928,305	2.00
3.00	Net patient revenues (line 1 minus line 2)	271,526,922	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	305,971,608	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-34,444,686	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	10,748,043	6.00
7.00	Income from investments	17,253,179	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	299,530	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	930,541	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	123,105	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	24,538	21.00
22.00	Rental of hospital space	340,722	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER: PHYSN REV, GRANTS, MISC. OTR	56,045,188	24.00
25.00	Total other income (sum of lines 6-24)	85,764,846	25.00
26.00	Total (line 5 plus line 25)	51,320,160	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)	51,320,160	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H | Date/Time Prepared: 11/26/2018 2:31 pm

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		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	1,103,269	280,475	75,188	89,941	358,681	1,907,554	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,898,684	0	0	0	0	1,898,684	6.00
7.00	Physical Therapy	503,289	0	0	0	0	503,289	7.00
8.00	Occupational Therapy	208,534	0	0	0	0	208,534	8.00
9.00	Speech Pathology	16,962	0	0	0	0	16,962	9.00
10.00	Medical Social Services	71,456	0	0	0	0	71,456	10.00
11.00	Home Health Aide	83,781	0	0	0	0	83,781	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	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,885,975	280,475	75,188	89,941	358,681	4,690,260	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	0	1,907,554	0	1,907,554			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,898,684	0	1,898,684			6.00
7.00	Physical Therapy	0	503,289	0	503,289			7.00
8.00	Occupational Therapy	0	208,534	0	208,534			8.00
9.00	Speech Pathology	0	16,962	0	16,962			9.00
10.00	Medical Social Services	0	71,456	0	71,456			10.00
11.00	Home Health Aide	0	83,781	0	83,781			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	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	4,690,260	0	4,690,260			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: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 11/26/2018 2:31 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	1,907,554	0	0	0	0	1,907,554	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,898,684	0	0	0	0	1,898,684	6.00
7.00	Physical Therapy	503,289	0	0	0	0	503,289	7.00
8.00	Occupational Therapy	208,534	0	0	0	0	208,534	8.00
9.00	Speech Pathology	16,962	0	0	0	0	16,962	9.00
10.00	Medical Social Services	71,456	0	0	0	0	71,456	10.00
11.00	Home Health Aide	83,781	0	0	0	0	83,781	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	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,690,260	0	0	0	0	4,690,260	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	1,907,554			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	1,301,554	3,200,238		6.00
7.00	Physical Therapy	345,006	848,295		7.00
8.00	Occupational Therapy	142,951	351,485		8.00
9.00	Speech Pathology	11,628	28,590		9.00
10.00	Medical Social Services	48,983	120,439		10.00
11.00	Home Health Aide	57,432	141,213		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)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		4,690,260		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part II | Date/Time Prepared: 11/26/2018 2:31 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	-1,907,554	2,782,706	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,898,684	6.00
7.00	Physical Therapy	0	0	0	0	0	503,289	7.00
8.00	Occupational Therapy	0	0	0	0	0	208,534	8.00
9.00	Speech Pathology	0	0	0	0	0	16,962	9.00
10.00	Medical Social Services	0	0	0	0	0	71,456	10.00
11.00	Home Health Aide	0	0	0	0	0	83,781	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	0	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	-1,907,554	2,782,706	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,907,554	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.685503	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-2 Part I Date/Time Prepared: 11/26/2018 2:31 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	50,250	36,863	856,469	943,582	185,780	1.00
2.00	Skilled Nursing Care	3,200,238	0	0	0	3,200,238	630,089	2.00
3.00	Physical Therapy	848,295	0	0	0	848,295	167,019	3.00
4.00	Occupational Therapy	351,485	0	0	0	351,485	69,203	4.00
5.00	Speech Pathology	28,590	0	0	0	28,590	5,629	5.00
6.00	Medical Social Services	120,439	0	0	0	120,439	23,713	6.00
7.00	Home Health Aide	141,213	0	0	0	141,213	27,803	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)	4,690,260	50,250	36,863	856,469	5,633,842	1,109,236	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	68,100	0	22,012	0	23,359	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) (2)	68,100	0	22,012	0	23,359	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

(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: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2018 2:31 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	17,665	1,260,498	0	1,260,498	1.00
2.00	Skilled Nursing Care	0	0	0	3,830,327	0	3,830,327	2.00
3.00	Physical Therapy	0	0	0	1,015,314	0	1,015,314	3.00
4.00	Occupational Therapy	0	0	0	420,688	0	420,688	4.00
5.00	Speech Pathology	0	0	0	34,219	0	34,219	5.00
6.00	Medical Social Services	0	0	0	144,152	0	144,152	6.00
7.00	Home Health Aide	0	0	0	169,016	0	169,016	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)	0	0	17,665	6,874,214	0	6,874,214	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	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	860,056	4,690,383					2.00
3.00	Physical Therapy	227,978	1,243,292					3.00
4.00	Occupational Therapy	94,461	515,149					4.00
5.00	Speech Pathology	7,684	41,903					5.00
6.00	Medical Social Services	32,368	176,520					6.00
7.00	Home Health Aide	37,951	206,967					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	1,260,498	6,874,214					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.	0.224539						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: 14-0189 HHA CCN: 14-7594

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

Worksheet H-2 Part II Date/Time Prepared: 11/26/2018 2:31 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	3,990	31,512	3,885,975	0	943,582	3,990	1.00
2.00	Skilled Nursing Care	0	0	0	0	3,200,238	0	2.00
3.00	Physical Therapy	0	0	0	0	848,295	0	3.00
4.00	Occupational Therapy	0	0	0	0	351,485	0	4.00
5.00	Speech Pathology	0	0	0	0	28,590	0	5.00
6.00	Medical Social Services	0	0	0	0	120,439	0	6.00
7.00	Home Health Aide	0	0	0	0	141,213	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)	3,990	31,512	3,885,975		5,633,842	3,990	20.00
21.00	Total cost to be allocated	50,250	36,863	856,469		1,109,236	68,100	21.00
22.00	Unit cost multiplier	12.593985	1.169808	0.220400		0.196888	17.067669	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	80	0	15	0	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)	0	80	0	15	0	0	20.00
21.00	Total cost to be allocated	0	22,012	0	23,359	0	0	21.00
22.00	Unit cost multiplier	0.000000	275.150000	0.000000	1,557.266667	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-2 Part II Date/Time Prepared: 11/26/2018 2:31 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
		15.00	16.00				
1.00	Administrative and General	0	5,369,363				1.00
2.00	Skilled Nursing Care	0	0				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	0	0				6.00
7.00	Home Health Aide	0	0				7.00
8.00	Supplies (see instructions)	0	0				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
19.50	Telemedicine	0	0				19.50
20.00	Total (sum of lines 1-19)	0	5,369,363				20.00
21.00	Total cost to be allocated	0	17,665				21.00
22.00	Unit cost multiplier	0.000000	0.003290				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 11/26/2018 2:31 pm

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	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	4,690,383		4,690,383	14,036	334.17	1.00
2.00	Physical Therapy	3.00	1,243,292	0	1,243,292	6,151	202.13	2.00
3.00	Occupational Therapy	4.00	515,149	0	515,149	2,547	202.26	3.00
4.00	Speech Pathology	5.00	41,903	0	41,903	231	181.40	4.00
5.00	Medical Social Services	6.00	176,520		176,520	240	735.50	5.00
6.00	Home Health Aide	7.00	206,967		206,967	2,304	89.83	6.00
7.00	Total (sum of lines 1-6)		6,874,214	0	6,874,214	25,509		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	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	11,400			8.00
9.00	Physical Therapy		99914	0	4,066			9.00
10.00	Occupational Therapy		99914	0	1,707			10.00
11.00	Speech Pathology		99914	0	136			11.00
12.00	Medical Social Services		99914	0	203			12.00
13.00	Home Health Aide		99914	0	1,878			13.00
14.00	Total (sum of lines 8-13)			0	19,390			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	0	0	0	0.000000	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	Part B Not Subject to Deductibles & Coinsurance	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	11,400		0	3,809,538		1.00
2.00	Physical Therapy	0	4,066		0	821,861		2.00
3.00	Occupational Therapy	0	1,707		0	345,258		3.00
4.00	Speech Pathology	0	136		0	24,670		4.00
5.00	Medical Social Services	0	203		0	149,307		5.00
6.00	Home Health Aide	0	1,878		0	168,701		6.00
7.00	Total (sum of lines 1-6)	0	19,390		0	5,319,335		7.00

	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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | Home Health Agency I | PPS

	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	0	0	0	0	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	3,809,538	1.00
2.00	Physical Therapy	821,861	2.00
3.00	Occupational Therapy	345,258	3.00
4.00	Speech Pathology	24,670	4.00
5.00	Medical Social Services	149,307	5.00
6.00	Home Health Aide	168,701	6.00
7.00	Total (sum of lines 1-6)	5,319,335	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: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part II Date/Time Prepared: 11/26/2018 2:31 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	0.247119	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.316339	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.328706	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.173825	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.195589	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/26/2018 2:31 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	2,596,749	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	364,950	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	67,205	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	53,422	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	144,597	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	9,243	16.00
17.00	Total Other Payments	0	-66,785	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	3,169,381	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,169,381	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	3,169,381	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	3,169,381	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	3,169,381	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	3,169,381	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	0	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: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-5 | Date/Time Prepared: 11/26/2018 2:31 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		3,169,381	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		3,169,381	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		3,169,381	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O | Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	103,653	103,653	0	103,653	3.00
4.00	ADMINISTRATIVE & GENERAL*	117,170	122,509	239,679	0	239,679	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	131	131	0	131	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	232,747	0	232,747	0	232,747	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	29,417	29,417	0	29,417	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	77,867	77,867	0	77,867	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	35,710	0	35,710	0	35,710	13.00
14.00	PHARMACY*	0	377,500	377,500	0	377,500	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	43,610	43,610	0	43,610	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	693,630	0	693,630	0	693,630	28.00
29.00	LPN/LVN**	32,045	0	32,045	0	32,045	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	106,663	0	106,663	0	106,663	33.00
34.00	SPIRITUAL COUNSELING**	52,671	0	52,671	0	52,671	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	104,913	0	104,913	0	104,913	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	221,705	221,705	0	221,705	38.00
39.00	PATIENT TRANSPORTATION**	0	13,574	13,574	0	13,574	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	34,156	34,156	0	34,156	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	56,904	0	56,904	0	56,904	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	207,281	21,784	229,065	0	229,065	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,639,734	1,045,906	2,685,640	0	2,685,640	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O | Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	103,653		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	239,679		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	131		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	232,747		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	29,417		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	77,867		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	35,710		13.00
14.00	PHARMACY*	0	377,500		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	43,610		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	693,630		28.00
29.00	LPN/LVN**	0	32,045		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	106,663		33.00
34.00	SPIRITUAL COUNSELING**	0	52,671		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	104,913		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	221,705		38.00
39.00	PATIENT TRANSPORTATION**	0	13,574		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	34,156		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	56,904		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	229,065		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	2,685,640		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-2 | Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	645,569	0	645,569	0	645,569	28.00
29.00	LPN/LVN	31,467	0	31,467	0	31,467	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	96,428	0	96,428	0	96,428	33.00
34.00	SPIRITUAL COUNSELING	49,405	0	49,405	0	49,405	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	104,163	0	104,163	0	104,163	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	221,705	221,705	0	221,705	38.00
39.00	PATIENT TRANSPORTATION	0	6,562	6,562	0	6,562	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2,065	2,065	0	2,065	46.00
100.00	TOTAL *	927,032	230,332	1,157,364	0	1,157,364	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	645,569		28.00
29.00	LPN/LVN	0	31,467		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	96,428		33.00
34.00	SPIRITUAL COUNSELING	0	49,405		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	104,163		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	221,705		38.00
39.00	PATIENT TRANSPORTATION	0	6,562		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2,065		46.00
100.00	TOTAL *	0	1,157,364		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-3 | Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	23,662	0	23,662	0	23,662	28.00
29.00	LPN/LVN	397	0	397	0	397	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,738	0	5,738	0	5,738	33.00
34.00	SPIRITUAL COUNSELING	1,595	0	1,595	0	1,595	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	750	0	750	0	750	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	3,258	3,258	0	3,258	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	9,388	9,388	0	9,388	46.00
100.00	TOTAL *	32,142	12,646	44,788	0	44,788	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	23,662		28.00
29.00	LPN/LVN	0	397		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,738		33.00
34.00	SPIRITUAL COUNSELING	0	1,595		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	750		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	3,258		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	9,388		46.00
100.00	TOTAL *	0	44,788		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-4

Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	24,399	0	24,399	0	24,399	28.00
29.00	LPN/LVN	181	0	181	0	181	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	4,497	0	4,497	0	4,497	33.00
34.00	SPIRITUAL COUNSELING	1,671	0	1,671	0	1,671	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	3,754	3,754	0	3,754	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	22,703	22,703	0	22,703	46.00
100.00	TOTAL *	30,748	26,457	57,205	0	57,205	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	24,399		28.00
29.00	LPN/LVN	0	181		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	4,497		33.00
34.00	SPIRITUAL COUNSELING	0	1,671		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	3,754		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	22,703		46.00
100.00	TOTAL *	0	57,205		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-5

Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	18,891	18,891	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	574	574	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	103,653	361,398	465,051	3.00
4.00	ADMINISTRATIVE & GENERAL	239,679	613,102	852,781	4.00
5.00	PLANT OPERATION & MAINTENANCE	131	25,601	25,732	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	8,805	8,805	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	232,747	0	232,747	9.00
10.00	ROUTINE MEDICAL SUPPLIES	29,417	0	29,417	10.00
11.00	MEDICAL RECORDS	0	21,394	21,394	11.00
12.00	STAFF TRANSPORTATION	77,867		77,867	12.00
13.00	VOLUNTEER SERVICE COORDINATION	35,710		35,710	13.00
14.00	PHARMACY	377,500	0	377,500	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	43,610		43,610	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,157,364		1,157,364	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	44,788		44,788	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	57,205		57,205	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	56,904		56,904	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	229,065		229,065	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,685,640	1,049,765	3,735,405	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,891	18,891				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	574		574			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	465,051	0	0	465,051		3.00
4.00	ADMINISTRATIVE & GENERAL	852,781	18,891	574	465,051	1,337,297	4.00
5.00	PLANT OPERATION & MAINTENANCE	25,732	0	0	0	25,732	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	8,805	0	0	0	8,805	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	232,747	0	0	0	232,747	9.00
10.00	ROUTINE MEDICAL SUPPLIES	29,417	0	0	0	29,417	10.00
11.00	MEDICAL RECORDS	21,394	0	0	0	21,394	11.00
12.00	STAFF TRANSPORTATION	77,867	0	0	0	77,867	12.00
13.00	VOLUNTEER SERVICE COORDINATION	35,710	0	0	0	35,710	13.00
14.00	PHARMACY	377,500	0	0	0	377,500	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	43,610	0	0	0	43,610	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,157,364			0	1,157,364	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	44,788	0	0	0	44,788	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	57,205	0	0	0	57,205	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	56,904	0	0	0	56,904	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	229,065	0	0	0	229,065	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,735,405	18,891	574	465,051	3,735,405	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,337,297					4.00
5.00	PLANT OPERATION & MAINTENANCE	14,349	40,081				5.00
6.00	LAUNDRY & LINEN SERVICE	0	40,081	40,081			6.00
7.00	HOUSEKEEPING	4,910	0		13,715		7.00
8.00	DIETARY	0	0		13,715	13,715	8.00
9.00	NURSING ADMINISTRATION	129,791	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	16,404	0		0		10.00
11.00	MEDICAL RECORDS	11,930	0		0		11.00
12.00	STAFF TRANSPORTATION	43,422	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	19,914	0		0		13.00
14.00	PHARMACY	210,512	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	24,319	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	645,401					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24,976	0	26,929	0	9,215	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	31,900	0	13,152	0	4,500	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	31,732	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	127,737	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,337,297	40,081	40,081	13,715	13,715	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0189 Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-6 Part I Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	362,538					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	45,821				10.00
11.00	MEDICAL RECORDS	0		33,324			11.00
12.00	STAFF TRANSPORTATION	0			121,289		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	55,624	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	342,573	45,572	33,143	120,631	55,303	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	10,361	167	122	442	214	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9,604	82	59	216	107	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	362,538	45,821	33,324	121,289	55,624	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	588,012					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	67,929				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	584,821	67,560	0		3,052,368	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,144	248	0	0	119,606	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,047	121	0	0	117,993	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		88,636	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		356,802	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	588,012	67,929	0	0	3,735,405	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/26/2018 2:31 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,500					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		491				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,639,735			3.00
4.00	ADMINISTRATIVE & GENERAL	1,500	491	1,639,735	-1,337,297	2,398,108	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	25,732	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	8,805	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	232,747	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	29,417	10.00
11.00	MEDICAL RECORDS	0	0	0	0	21,394	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	77,867	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	35,710	13.00
14.00	PHARMACY	0	0	0	0	377,500	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	43,610	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	1,157,364	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	44,788	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	57,205	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	56,904	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	229,065	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	18,891	574	465,051		1,337,297	100.00
101.00	UNIT COST MULTIPLIER	12.594000	1.169043	0.283614		0.557647	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/26/2018 2:31 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,500					5.00
6.00	LAUNDRY & LINEN SERVICE	1,500	128				6.00
7.00	HOUSEKEEPING	0		1,500			7.00
8.00	DIETARY	0		1,500	128		8.00
9.00	NURSING ADMINISTRATION	0		0		25,858	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					24,434	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	86	0	86	739	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	42	0	42	685	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	40,081	40,081	13,715	13,715	362,538	100.00
101.00	UNIT COST MULTIPLIER	26.720667	313.132813	9.143333	107.148438	14.020342	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	23,587					10.00
11.00	MEDICAL RECORDS		23,587				11.00
12.00	STAFF TRANSPORTATION			23,587			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	2,077		13.00
14.00	PHARMACY			0	0	23,587	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	23,459	23,459	23,459	2,065	23,459	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	86	86	86	8	86	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	42	42	42	4	42	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	45,821	33,324	121,289	55,624	588,012	100.00
101.00	UNIT COST MULTIPLIER	1.942638	1.412812	5.142197	26.780934	24.929495	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/26/2018 2:31 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	23,587				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	23,459	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	86	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	42	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	67,929	0	0		100.00
101.00	UNIT COST MULTIPLIER	2.879934	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-7

Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.247119	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.316339	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.328706	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.195589	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.257459	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.173825	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.365298	0	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	9.580072	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-8 | Date/Time Prepared: 11/26/2018 2:31 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			3,052,368	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			23,459	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			130.12	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	21,614	1,038		9.00
10.00	Program cost (line 8 times line 9)	2,812,414	135,065		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			119,606	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			86	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,390.77	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	76	0		14.00
15.00	Program cost (line 13 times line 14)	105,699	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			117,993	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			42	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,809.36	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	33	8		19.00
20.00	Program cost (line 18 times line 19)	92,709	22,475		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,289,967	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			23,587	22.00
23.00	Average cost per diem (line 21 divided by line 22)			139.48	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0189	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,602,391	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	29,525	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)	50.97	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)	1,631,916	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: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 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	48,002	3,590	51,592	0	51,592	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	128,869	10,245	139,114	0	139,114	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	120,256	7,917	128,173	0	128,173	9.00
10.00	Subtotal (sum of lines 1 through 9)	297,127	21,752	318,879	0	318,879	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	34,864	34,864	0	34,864	15.00
16.00	Transportation (Health Care Staff)	0	632	632	0	632	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	5,244	5,244	0	5,244	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,740	40,740	0	40,740	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	297,127	62,492	359,619	0	359,619	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	75,834	75,834	0	75,834	29.00
30.00	Administrative Costs	25,861	4,611	30,472	0	30,472	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,861	80,445	106,306	0	106,306	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	322,988	142,937	465,925	0	465,925	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 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	0	51,592		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	139,114		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	128,173		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	318,879		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	34,864		15.00
16.00	Transportation (Health Care Staff)	0	632		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	5,244		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,740		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	359,619		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	75,834		29.00
30.00	Administrative Costs	0	30,472		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	106,306		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	465,925		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC II | 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	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	233,452	24,903	258,355	0	258,355	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	96,679	5,363	102,042	0	102,042	9.00
10.00	Subtotal (sum of lines 1 through 9)	330,131	30,266	360,397	0	360,397	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	35,868	35,868	0	35,868	15.00
16.00	Transportation (Health Care Staff)	0	1,170	1,170	0	1,170	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	10,487	10,487	0	10,487	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,525	47,525	0	47,525	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	330,131	77,791	407,922	0	407,922	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	60,186	60,186	0	60,186	29.00
30.00	Administrative Costs	62,008	5,104	67,112	0	67,112	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,008	65,290	127,298	0	127,298	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	392,139	143,081	535,220	0	535,220	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	258,355		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	102,042		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	360,397		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	35,868		15.00
16.00	Transportation (Health Care Staff)	0	1,170		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	10,487		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,525		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	407,922		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	60,186		29.00
30.00	Administrative Costs	0	67,112		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	127,298		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	535,220		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC III | 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	205,616	22,982	228,598	0	228,598	1.00
2.00	Physician Assistant	307,266	10,862	318,128	0	318,128	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	157,947	6,381	164,328	0	164,328	9.00
10.00	Subtotal (sum of lines 1 through 9)	670,829	40,225	711,054	0	711,054	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	22,683	22,683	0	22,683	15.00
16.00	Transportation (Health Care Staff)	0	1,975	1,975	0	1,975	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	18,352	18,352	0	18,352	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	43,010	43,010	0	43,010	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	670,829	83,235	754,064	0	754,064	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	76,214	76,214	0	76,214	29.00
30.00	Administrative Costs	73,724	7,107	80,831	0	80,831	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,724	83,321	157,045	0	157,045	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	744,553	166,556	911,109	0	911,109	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	228,598		1.00
2.00	Physician Assistant	0	318,128		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	164,328		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	711,054		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	22,683		15.00
16.00	Transportation (Health Care Staff)	0	1,975		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	18,352		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	43,010		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	754,064		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	76,214		29.00
30.00	Administrative Costs	0	80,831		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	157,045		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	911,109		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC IV | 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	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	244,673	24,188	268,861	0	268,861	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	161,378	9,061	170,439	0	170,439	9.00
10.00	Subtotal (sum of lines 1 through 9)	406,051	33,249	439,300	0	439,300	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	72,383	72,383	0	72,383	15.00
16.00	Transportation (Health Care Staff)	0	1,111	1,111	0	1,111	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	10,487	10,487	0	10,487	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	83,981	83,981	0	83,981	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	406,051	117,230	523,281	0	523,281	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	49,287	49,287	0	49,287	29.00
30.00	Administrative Costs	82,283	6,861	89,144	0	89,144	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	82,283	56,148	138,431	0	138,431	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	488,334	173,378	661,712	0	661,712	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	268,861		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	170,439		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	439,300		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	72,383		15.00
16.00	Transportation (Health Care Staff)	0	1,111		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	10,487		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	83,981		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	523,281		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	49,287		29.00
30.00	Administrative Costs	0	89,144		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	138,431		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	661,712		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC V | 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	763,804	32,233	796,037	0	796,037	1.00
2.00	Physician Assistant	93,995	8,812	102,807	0	102,807	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	158,603	6,353	164,956	0	164,956	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,016,402	47,398	1,063,800	0	1,063,800	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	101,535	101,535	0	101,535	15.00
16.00	Transportation (Health Care Staff)	0	2,321	2,321	0	2,321	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	31,461	31,461	0	31,461	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	135,317	135,317	0	135,317	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,016,402	182,715	1,199,117	0	1,199,117	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	79,047	79,047	0	79,047	29.00
30.00	Administrative Costs	180,621	32,203	212,824	0	212,824	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	180,621	111,250	291,871	0	291,871	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,197,023	293,965	1,490,988	0	1,490,988	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	796,037		1.00
2.00	Physician Assistant	0	102,807		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	164,956		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,063,800		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	101,535		15.00
16.00	Transportation (Health Care Staff)	0	2,321		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	31,461		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	135,317		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,199,117		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	79,047		29.00
30.00	Administrative Costs	0	212,824		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	291,871		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,490,988		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 2:31 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	0.20	464	2,100	420		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.89	2,445	2,100	1,869		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.09	2,909		2,289	2,909	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)	1.09	2,909			2,909	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)					359,619	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)					359,619	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)					106,306	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					629,566	15.00
16.00	Total overhead (sum of lines 14 and 15)					735,872	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					735,872	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					735,872	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,095,491	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC II | 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	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.55	3,688	4,200	6,510		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.55	3,688		6,510	6,510	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)	1.55	3,688			6,510	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)					407,922	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)					407,922	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)					127,298	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					432,812	15.00
16.00	Total overhead (sum of lines 14 and 15)					560,110	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					560,110	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					560,110	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					968,032	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC III | 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	0.53	2,801	2,100	1,113		1.00
2.00	Physician Assistant	0.81	3,651	2,100	1,701		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.34	6,452		2,814	6,452	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)	1.34	6,452			6,452	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)					754,064	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)					754,064	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)					157,045	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					475,501	15.00
16.00	Total overhead (sum of lines 14 and 15)					632,546	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					632,546	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					632,546	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,386,610	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC IV | 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	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.50	5,646	4,200	6,300		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.50	5,646		6,300	6,300	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)	1.50	5,646			6,300	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)					523,281	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)					523,281	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)					138,431	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					378,464	15.00
16.00	Total overhead (sum of lines 14 and 15)					516,895	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					516,895	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					516,895	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,040,176	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 2:31 pm

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.71	11,273	2,100	3,591		1.00
2.00	Physician Assistant	0.73	3,223	2,100	1,533		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.44	14,496		5,124	14,496	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)	2.44	14,496			14,496	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)					1,199,117	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)					1,199,117	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)					291,871	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					939,154	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,231,025	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,231,025	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,231,025	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,430,142	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 2:31 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)			1,095,491	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			2,559	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,092,932	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,909	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)			2,909	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			375.71	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)	82.30	83.45		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	352	487		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	28,970	40,640		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	69,610		16.00
16.01	Total program charges (see instructions)(from contractor's records)		107,926		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.)		42,913		16.04
16.05	Total program cost (see instructions)	0	42,913		16.05
17.00	Primary payer amounts		62		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,969		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,391		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,851		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		384		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		43,235		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		43,235		26.00
26.01	Sequestration adjustment (see instructions)		865		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		41,214		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)		1,156		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	RHC II	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)			968,032	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,316	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			962,716	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,510	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)			6,510	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			147.88	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	379	448		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	31,192	37,386		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	68,578		16.00
16.01	Total program charges (see instructions)(from contractor's records)		121,564		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.)		39,862		16.04
16.05	Total program cost (see instructions)	0	39,862		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,751		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,563		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		39,862		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		631		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		40,493		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		40,493		26.00
26.01	Sequestration adjustment (see instructions)		810		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		38,117		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)		1,566		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3435	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	RHC III	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)	1,386,610	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	2,575	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,384,035	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	6,452	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)	6,452	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	214.51	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)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,144	1,284	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	94,151	107,150	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	201,301	16.00
16.01	Total program charges (see instructions)(from contractor's records)		346,208	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.)		131,662	16.04
16.05	Total program cost (see instructions)	0	131,662	16.05
17.00	Primary payer amounts		51	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,724	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		61,897	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		131,611	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,983	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		133,594	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		133,594	26.00
26.01	Sequestration adjustment (see instructions)		2,672	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		126,710	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)		4,212	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-8541	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	RHC IV	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)			1,040,176	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,236	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,032,940	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,300	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)			6,300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			163.96	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)	82.30	83.45		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	554	592		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	45,594	49,402		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	94,996		16.00
16.01	Total program charges (see instructions)(from contractor's records)		147,123		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.)		58,252		16.04
16.05	Total program cost (see instructions)	0	58,252		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,181		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,989		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		58,252		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,753		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		60,005		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		60,005		26.00
26.01	Sequestration adjustment (see instructions)		1,200		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		55,885		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)		2,920		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-8555	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 2:31 pm
	Title XVIII	RHC V	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)		2,430,142	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		4,256	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,425,886	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,496	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)		14,496	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		167.35	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)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,919	1,909	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	157,934	159,306	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	317,240	16.00
16.01	Total program charges (see instructions)(from contractor's records)		458,626	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.)		205,180	16.04
16.05	Total program cost (see instructions)	0	205,180	16.05
17.00	Primary payer amounts		63	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		60,765	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		79,574	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		205,117	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		567	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		205,684	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		205,684	26.00
26.01	Sequestration adjustment (see instructions)		4,114	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		200,198	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)		1,372	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: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 2:31 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)	318,879	318,879	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	840	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	840	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	359,619	359,619	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	735,872	735,872	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.002336	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	1,719	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	2,559	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	60	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	42.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	9	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	384	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)		2,559	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)		384	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	360,397	360,397	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	2,240	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	2,240	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	407,922	407,922	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	560,110	560,110	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.005491	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	3,076	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	5,316	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	160	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	33.22	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	19	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	631	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)		5,316	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)		631	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | RHC III | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	711,054	711,054	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	1,400	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	1,400	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	754,064	754,064	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	632,546	632,546	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001857	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	1,175	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	2,575	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	100	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	25.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	77	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	1,983	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)		2,575	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)		1,983	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | RHC IV | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	439,300	439,300	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	3,640	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	3,640	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	523,281	523,281	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	516,895	516,895	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.006956	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	3,596	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	7,236	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	260	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	27.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	63	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	1,753	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)		7,236	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)		1,753	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 2:31 pm

Title XVIII | RHC V | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,063,800	1,063,800	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	2,100	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	2,100	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,199,117	1,199,117	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,231,025	1,231,025	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001751	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	2,156	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	4,256	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	150	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	28.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	20	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	567	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)		4,256	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)		567	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 2:31 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		41,214	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)		41,214	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		1,156	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		42,370	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 2:31 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		38,117	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)		38,117	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		1,566	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		39,683	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3435	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 2:31 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		126,710	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)		126,710	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		4,212	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		130,922	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-8541	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 2:31 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		55,885	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)		55,885	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		2,920	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		58,805	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-8555	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 2:31 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		200,198	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)		200,198	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		1,372	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		201,570	7.00

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