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: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 12/18/2018 12:32 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/18/2018 Time: 12:32 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 HARRISBURG MEDICAL CENTER, INC. (14-0210) 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.

[X] 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) JUNE HAYES
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	129,394	-386	0	0	1.00
2.00	Subprovider - IPF	0	13,220	2		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-39		0	9.00
10.00	RURAL HEALTH CLINIC I	0		28,785		0	10.00
10.01	RURAL HEALTH CLINIC II	0		8,304		0	10.01
10.02	RURAL HEALTH CLINIC III	0		14,844		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		26,573		0	10.03
10.04	RURAL HEALTH CLINIC V	0		20,825		0	10.04
200.00	Total	0	142,614	98,908	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/17/2018 2:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 100 DR WARREN TUTTLE DRIVE	PO Box:			1.00
2.00	City: HARRISBURG	State: IL	Zip Code: 62946	County: SALINE	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	HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HARRISBURG MEDICAL CENTER, INC.	147419	99914		08/15/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	EQUALITY FAMILY PRACTICE	148518	99914		09/27/2011	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	GALATIA PRIMARY CARE	148560	99914		05/10/2016	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	HMC AT HARRISBURG	148589	99914		06/05/2018	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	HARRISBUG MEDICAL CENTER	148590	99914		06/05/2018	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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	595	215	3	2	149	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/17/2018 2:39 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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/17/2018 2:39 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.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/17/2018 2:39 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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	92,641	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/17/2018 2:39 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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	09/28/2017	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 12/17/2018 2:39 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2018	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	11/01/2018	Y	11/01/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 12/17/2018 2:39 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 12/17/2018 2:39 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 12/17/2018 2:39 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	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)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		38	13,870	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	30	10,950		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						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	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)		68				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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,559	595	5,506			1.00
2.00	HMO and other (see instructions)	427	369				2.00
3.00	HMO IPF Subprovider	152	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	103	0	103			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	53			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,662	595	5,662			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)	3,662	595	5,662	0.00	413.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,709	4,616	8,806	0.00	56.87	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,521	0	3,370	0.00	9.49	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,591	0	17,614	0.00	22.28	26.00
26.01	RURAL HEALTH CLINIC II	376	0	2,107	0.00	3.05	26.01
26.02	RURAL HEALTH CLINIC III	405	0	2,515	0.00	3.30	26.02
26.03	RURAL HEALTH CLINIC IV	146	0	694	0.00	0.88	26.03
26.04	RURAL HEALTH CLINIC V	158	0	611	0.00	0.63	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	510.06	27.00
28.00	Observation Bed Days		0	1,548			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,063	354	1,802	1.00
2.00	HMO and other (see instructions)			169	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	1,063	354	1,802	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	294	608	1,128	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 12/17/2018 2:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	29,096,134	0	29,096,134	1,130,424.24	25.74	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		727,594	0	727,594	6,608.00	110.11	3.00
4.00	Physician-Part A - Administrative		65,591	0	65,591	522.00	125.65	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		6,080,865	-198,345	5,882,520	58,243.23	101.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,669,553	-229,447	1,440,106	59,539.37	24.19	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)		4,244,895	239,466	4,484,361	176,751.57	25.37	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		209,483	0	209,483	3,437.75	60.94	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		12,000	0	12,000	60.00	200.00	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)		6,465,027	0	6,465,027			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,475,956	0	1,475,956			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		95,622	0	95,622			21.00
22.00	Physician Part A - Administrative		7,929	0	7,929			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		818,272	0	818,272			23.00
24.00	Wage-related costs (RHC/FQHC)		491,579	0	491,579			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	128,587	0	128,587	6,175.41	20.82	26.00
27.00	Administrative & General	5.00	3,605,014	54,759	3,659,773	154,662.96	23.66	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 12/17/2018 2:39 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		322,193	0	322,193	3,529.40	91.29	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	478,260	0	478,260	29,807.06	16.05	30.00
31.00	Laundry & Linen Service	8.00	51,686	0	51,686	4,516.25	11.44	31.00
32.00	Housekeeping	9.00	567,770	0	567,770	47,011.45	12.08	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	625,999	0	625,999	48,219.34	12.98	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	112,543	0	112,543	4,327.75	26.00	38.00
39.00	Central Services and Supply	14.00	279,323	0	279,323	21,445.54	13.02	39.00
40.00	Pharmacy	15.00	620,736	0	620,736	14,543.11	42.68	40.00
41.00	Medical Records & Medical Records Library	16.00	534,416	0	534,416	31,932.88	16.74	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 12/17/2018 2:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		20,940,315	427,792	21,368,107	1,009,563.04	21.17	1.00
2.00	Excluded area salaries (see instructions)		4,244,895	239,466	4,484,361	176,751.57	25.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)		16,695,420	188,326	16,883,746	832,811.47	20.27	3.00
4.00	Subtotal other wages & related costs (see inst.)		221,483	0	221,483	3,497.75	63.32	4.00
5.00	Subtotal wage-related costs (see inst.)		6,472,956	0	6,472,956	0.00	38.34	5.00
6.00	Total (sum of lines 3 thru 5)		23,389,859	188,326	23,578,185	836,309.22	28.19	6.00
7.00	Total overhead cost (see instructions)		7,326,527	54,759	7,381,286	366,171.15	20.16	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 12/17/2018 2:39 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	778,050	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,257,311	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	87,317	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,751	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	160,400	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	1,582,863	17.00
18.00	Medicare Taxes - Employers Portion Only	370,186	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	74,630	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	5,877	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,354,385	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	320,356	9,354,385	1.00
2.00	Hospital	209,483	7,387,135	2.00
3.00	Subprovider - IPF	110,873	941,142	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	161,183	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	645,836	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	80,403	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	85,490	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	31,221	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	21,975	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	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-4 | Date/Time Prepared: 12/17/2018 2:39 pm

Home Health Agency I | PPS

						1.00	
0.00	County				SALINE		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	135.00	143.00	178.00	456.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			5.32	0.00	5.32	6.00
7.00	Nursing Supervisor			1.77	0.00	1.77	7.00
8.00	Physical Therapy Service			1.33	0.00	1.33	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.03	0.00	0.03	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	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	711	18	114	13	856	21.00
22.00	Skilled Nursing Visit Charges	167,085	4,230	26,790	3,055	201,160	22.00
23.00	Physical Therapy Visits	607	8	10	16	641	23.00
24.00	Physical Therapy Visit Charges	143,252	1,888	2,360	3,776	151,276	24.00
25.00	Occupational Therapy Visits	13	0	0	0	13	25.00
26.00	Occupational Therapy Visit Charges	3,315	0	0	0	3,315	26.00
27.00	Speech Pathology Visits	6	0	5	0	11	27.00
28.00	Speech Pathology Visit Charges	1,530	0	1,275	0	2,805	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,337	26	129	29	1,521	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)	315,182	6,118	30,425	6,831	358,556	35.00
36.00	Total Number of Episodes (standard/non outlier)	120		44	2	166	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	15,523	1,220	5,596	19	22,358	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 12/17/2018 2:39 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/03/1988	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	35	35	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	18	18	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	5	5	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	5	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	3	3	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	26	26	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 12/17/2018 2:39 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	6	6	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	5	5	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	103	103	200.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1007 USE ROUTE 45	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ELDORADO	IL	62930	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		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	20:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SALINE				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	20:00	08:00	20:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210
Component CCN: 14-3473

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

Worksheet S-8
Date/Time Prepared:
12/17/2018 2:39 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:50				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			183 WEST LN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	EQUALITY		IL	62934	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		GALLATIN				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	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			124 E MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GALATIA		IL	62935	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SALINE				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: 14-0210
Component CCN: 14-8560

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

Worksheet S-8
Date/Time Prepared:
12/17/2018 2:39 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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8589 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			901 S COMMERCIAL		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HARRISBURG		IL	62946	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		SALINE				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: 14-0210
Component CCN: 14-8589

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

Worksheet S-8
Date/Time Prepared:
12/17/2018 2:39 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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3106 OUTER DRIVE STE 300		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MARION		IL	62959	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		WILLIAMSON				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: 14-0210 | Component CCN: 14-8590 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 12/17/2018 2:39 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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 12/17/2018 2:39 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.334102	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,713,804	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,698,663	5.00
6.00	Medicaid charges	28,573,620	6.00
7.00	Medicaid cost (line 1 times line 6)	9,546,504	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,134,037	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	28,102	9.00
10.00	Stand-alone CHIP charges	140,390	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	46,905	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	18,803	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,152,840	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)	677,103	2,336,084	3,013,187	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,221	2,336,084	2,562,305	21.00
22.00	Payments received from patients for amounts previously written off as charity care	18,253	0	18,253	22.00
23.00	Cost of charity care (line 21 minus line 22)	207,968	2,336,084	2,544,052	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)	2,104,223	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	540,155	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	831,008	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,273,215	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	716,237	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,260,289	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,413,129	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,687,605	2,687,605	-1,263,154	1,424,451	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,739,684	1,739,684	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	128,587	9,431,821	9,560,408	0	9,560,408	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,605,014	4,237,850	7,842,864	-43,569	7,799,295	5.00
7.00	00700	OPERATION OF PLANT	478,260	721,832	1,200,092	0	1,200,092	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,686	122,864	174,550	0	174,550	8.00
9.00	00900	HOUSEKEEPING	567,770	99,833	667,603	0	667,603	9.00
10.00	01000	DIETARY	625,999	352,694	978,693	0	978,693	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	112,543	3,489	116,032	0	116,032	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	279,323	208,910	488,233	0	488,233	14.00
15.00	01500	PHARMACY	620,736	1,252	621,988	0	621,988	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	534,416	260,513	794,929	0	794,929	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	727,594	727,594	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,860,625	866,535	5,727,160	0	5,727,160	30.00
40.00	04000	SUBPROVIDER - IPF	2,303,953	990,236	3,294,189	0	3,294,189	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	799,652	553,776	1,353,428	0	1,353,428	50.00
53.00	05300	ANESTHESIOLOGY	980,747	60,031	1,040,778	-727,594	313,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,784	188,059	649,843	87,909	737,752	54.00
54.01	05401	ULTRASOUND	197,626	20,131	217,757	0	217,757	54.01
54.02	03440	MAMMOGRAPHY	66,957	62,783	129,740	0	129,740	54.02
56.00	05600	RADIOISOTOPE	169,929	284,156	454,085	0	454,085	56.00
57.00	05700	CT SCAN	187,784	145,325	333,109	0	333,109	57.00
60.00	06000	LABORATORY	896,289	9,907,584	10,803,873	45,658	10,849,531	60.00
64.00	06400	INTRAVENOUS THERAPY	89	0	89	0	89	64.00
65.00	06500	RESPIRATORY THERAPY	602,634	154,084	756,718	0	756,718	65.00
66.00	06600	PHYSICAL THERAPY	584,660	18,088	602,748	0	602,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,670	4,982	172,652	0	172,652	67.00
68.00	06800	SPEECH PATHOLOGY	103,007	1,975	104,982	0	104,982	68.00
69.00	06900	ELECTROCARDIOLOGY	101,617	106,585	208,202	0	208,202	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,224,560	2,224,560	-1,495,348	729,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,495,348	1,495,348	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,394,246	1,394,246	0	1,394,246	73.00
75.00	07500	ASC (NON-DISTINCT PART)	647,819	127,695	775,514	0	775,514	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	134,745	10,907	145,652	0	145,652	76.00
76.97	07697	CARDIAC REHABILITATION	94,836	24,398	119,234	0	119,234	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,693,479	321,096	2,014,575	27,475	2,042,050	88.00
88.01	08801	RURAL HEALTH CLINIC II	196,232	60,790	257,022	-6,958	250,064	88.01
88.02	08802	RURAL HEALTH CLINIC III	208,646	81,521	290,167	-1,454	288,713	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,069,706	482,440	1,552,146	-276,694	1,275,452	88.03
88.04	08804	RURAL HEALTH CLINIC V	752,945	384,598	1,137,543	-203,157	934,386	88.04
91.00	09100	EMERGENCY	2,867,427	694,067	3,561,494	0	3,561,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	448,143	58,825	506,968	-57,079	449,889	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		479,896	479,896	-479,896	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,603,335	37,838,032	65,441,367	-431,235	65,010,132	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,403,736	288,962	1,692,698	456,561	2,149,259	192.00
194.00	07950	RETAIL 340B PHARMACY	0	252,504	252,504	0	252,504	194.00
194.01	07951	AUXILIARY	41,339	656	41,995	0	41,995	194.01
194.02	07952	FOUNDATION	47,724	134,531	182,255	-25,326	156,929	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	29,096,134	38,514,685	67,610,819	0	67,610,819	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-286,599	1,137,852		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,739,684		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,968,964	7,591,444		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-732,100	7,067,195		5.00
7.00	00700	OPERATION OF PLANT	-17,916	1,182,176		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	174,550		8.00
9.00	00900	HOUSEKEEPING	-32,639	634,964		9.00
10.00	01000	DIETARY	-116,085	862,608		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-5,478	110,554		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-5,305	482,928		14.00
15.00	01500	PHARMACY	-42,168	579,820		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-609	794,320		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-727,594	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,121,682	3,605,478		30.00
40.00	04000	SUBPROVIDER - IPF	-320,894	2,973,295		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-45,023	1,308,405		50.00
53.00	05300	ANESTHESIOLOGY	-253,153	60,031		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	737,752		54.00
54.01	05401	ULTRASOUND	0	217,757		54.01
54.02	03440	MAMMOGRAPHY	0	129,740		54.02
56.00	05600	RADIOISOTOPE	0	454,085		56.00
57.00	05700	CT SCAN	14	333,123		57.00
60.00	06000	LABORATORY	-4,491	10,845,040		60.00
64.00	06400	INTRAVENOUS THERAPY	0	89		64.00
65.00	06500	RESPIRATORY THERAPY	-26,792	729,926		65.00
66.00	06600	PHYSICAL THERAPY	152	602,900		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	172,652		67.00
68.00	06800	SPEECH PATHOLOGY	0	104,982		68.00
69.00	06900	ELECTROCARDIOLOGY	-62,432	145,770		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	729,212		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,495,348		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,394,246		73.00
75.00	07500	ASC (NON-DISTINCT PART)	103	775,617		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	145,652		76.00
76.97	07697	CARDIAC REHABILITATION	-21,242	97,992		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-14,043	2,028,007		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	250,064		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	288,713		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-1,165,173	110,279		88.03
88.04	08804	RURAL HEALTH CLINIC V	-853,936	80,450		88.04
91.00	09100	EMERGENCY	-2,252,188	1,309,306		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	449,889		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,076,237	53,933,895		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,149,259		192.00
194.00	07950	RETAIL 340B PHARMACY	0	252,504		194.00
194.01	07951	AUXILIARY	0	41,995		194.01
194.02	07952	FOUNDATION	0	156,929		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,076,237	56,534,582		200.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/17/2018 2:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXP & BOND AMORT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	479,896		1.00
	0		0	479,896		
	B - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,685,610		1.00
	0		0	1,685,610		
	C - OFFSITE PROPERTY DEPRECIATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,134		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	148,784		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	3,893		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,092		4.00
	0		0	177,903		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	174,537		1.00
	0		0	174,537		
	E - HOME HEALTH BILLERS					
1.00	ADMINISTRATIVE & GENERAL	5.00	54,759	0		1.00
	0		54,759	0		
	F - LAB TECHS					
1.00	LABORATORY	60.00	45,658	0		1.00
	0		45,658	0		
	G - RADIOLOGY TECHS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	87,909	0		1.00
2.00		0.00	0	0		2.00
	0		87,909	0		
	I - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,495,348		1.00
	0		0	1,495,348		
	J - CRNA SALARIES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	727,594	0		1.00
	0		727,594	0		
	K - PRE-RHC CERTIFICATION COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	324,582	154,404		1.00
2.00		0.00	0	0		2.00
	TOTALS		324,582	154,404		
	L - ALLOWABLE ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,326		1.00
	TOTALS		0	25,326		
	M - A&G COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,749		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
	TOTALS		0	39,749		
500.00	Grand Total: Increases		1,240,502	4,232,773		500.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/17/2018 2:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXP & BOND AMORT						
1.00	INTEREST EXPENSE	113.00	0	479,896	11		1.00
	0		0	479,896			
	B - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,685,610	9		1.00
	0		0	1,685,610			
	C - OFFSITE PROPERTY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	177,903	9		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
	0		0	177,903			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,537	0		1.00
	0		0	174,537			
	E - HOME HEALTH BILLERS						
1.00	HOME HEALTH AGENCY	101.00	54,759	0	0		1.00
	0		54,759	0			
	F - LAB TECHS						
1.00	RURAL HEALTH CLINIC	88.00	45,658	0	0		1.00
	0		45,658	0			
	G - RADIOLOGY TECHS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	30,357	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	57,552	0	0		2.00
	0		87,909	0			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,495,348	0		1.00
	0		0	1,495,348			
	J - CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	727,594	0	0		1.00
	0		727,594	0			
	K - PRE-RHC CERTIFICATION COSTS						
1.00	RURAL HEALTH CLINIC IV	88.03	190,496	85,914	0		1.00
2.00	RURAL HEALTH CLINIC V	88.04	134,086	68,490	0		2.00
	TOTALS		324,582	154,404			
	L - ALLOWABLE ADVERTISING						
1.00	FOUNDATION	194.02	0	25,326	0		1.00
	TOTALS		0	25,326			
	M - A&G COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	18,099	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	6,958	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	5,347	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	284	0		4.00
5.00	RURAL HEALTH CLINIC V	88.04	0	581	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	2,320	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,160	0		7.00
	TOTALS		0	39,749			
500.00	Grand Total: Decreases		1,240,502	4,232,773			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	810,438	15,713	0	15,713	7,958	1.00
2.00	Land Improvements	851,102	118,244	0	118,244	45,543	2.00
3.00	Buildings and Fixtures	24,950,101	12,690,488	0	12,690,488	406,159	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,168,767	3,480,013	0	3,480,013	1,185,052	6.00
7.00	HIT designated Assets	1,032,011	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,812,419	16,304,458	0	16,304,458	1,644,712	8.00
9.00	Reconciling Items	-5,106,287	-7,433,212	0	-7,433,212	-12,358,931	9.00
10.00	Total (line 8 minus line 9)	46,918,706	23,737,670	0	23,737,670	14,003,643	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	818,193	0	1.00
2.00	Land Improvements	923,803	0	2.00
3.00	Buildings and Fixtures	37,234,430	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,463,728	0	6.00
7.00	HIT designated Assets	1,032,011	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,472,165	0	8.00
9.00	Reconciling Items	-180,568	0	9.00
10.00	Total (line 8 minus line 9)	56,652,733	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,687,605	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)	2,687,605	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	2,687,605		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,687,605		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,976,426	0	38,976,426	0.690188	120,463	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,495,739	0	17,495,739	0.309812	54,074	2.00
3.00	Total (sum of lines 1-2)	56,472,165	0	56,472,165	1.000000	174,537	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	120,463	824,092	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	54,074	1,685,610	0	2.00
3.00	Total (sum of lines 1-2)	0	0	174,537	2,509,702	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	193,297	120,463	0	0	1,137,852	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	54,074	0	0	1,739,684	2.00
3.00	Total (sum of lines 1-2)	193,297	174,537	0	0	2,877,536	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-286,599	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-544	ADMINISTRATIVE & GENERAL	5.00	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)	A	-13,784	ADMINISTRATIVE & GENERAL	5.00	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	-5,078,955			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	-116,085	DIETARY	10.00	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	-609	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	-5,497	ADMINISTRATIVE & GENERAL	5.00	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	A	-727,594	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	MISC INCOME - A&G	B	-123,772	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - ER	B	-1,025	EMERGENCY	91.00	0	33.01
33.02	SIH RESERVE BH INCOME	B	-33,643	SUBPROVIDER - IPF	40.00	0	33.02
33.03	PARKING LOT RENTAL INCOME	B	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	SIH INCOME ON CEO RECRUITMENT	B	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
34.00	RENTAL INCOME	B	-11,000	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CRNA BENEFITS	A	-233,921	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
35.01	PHYSICIAN BENEFITS	A	-1,231,152	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.01
36.00	LLC OVERHEAD FRINGE BENEFIT	A	-501,774	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	LLC OVERHEAD A&G	A	-74,910	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	LLC OVERHEAD PLANT	A	-17,951	OPERATION OF PLANT	7.00	0	36.02
36.03	LLC OVERHEAD HOUSEKEEPING	A	-32,639	HOUSEKEEPING	9.00	0	36.03
36.04	LLC OVERHEAD NURSING ADMIN	A	-5,478	NURSING ADMINISTRATION	13.00	0	36.04
36.05	LLC OVERHEAD CENTRAL SUPPLY	A	-5,305	CENTRAL SERVICES & SUPPLY	14.00	0	36.05
36.06	LLC OVERHEAD PHARMACY	A	-42,168	PHARMACY	15.00	0	36.06
36.07	LLC OVERHEAD RHC I	A	-14,043	RURAL HEALTH CLINIC	88.00	0	36.07
37.00	CAPITALIZED INTEREST	A	35	OPERATION OF PLANT	7.00	0	37.00
37.01	CAPITALIZED INTEREST	A	77	OPERATING ROOM	50.00	0	37.01
37.02	CAPITALIZED INTEREST	A	14	CT SCAN	57.00	0	37.02
37.03	CAPITALIZED INTEREST	A	152	PHYSICAL THERAPY	66.00	0	37.03
37.04	CAPITALIZED INTEREST	A	103	ASC (NON-DISTINCT PART)	75.00	0	37.04
37.05	CAPITALIZED INTEREST	A	90	EMERGENCY	91.00	0	37.05
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
38.01	IHREF CONTRIBUTION EXPENSE	A	-8,722	ADMINISTRATIVE & GENERAL	5.00	0	38.01
38.02	INSURANCE SETTLEMENTS	A	-5,966	ADMINISTRATIVE & GENERAL	5.00	0	38.02
39.00	COMM RELATIONS	A	-1,398	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	COMM RELATIONS	A	-13,874	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	PHYSICIAN RECRUITMENT	A	-124,751	ADMINISTRATIVE & GENERAL	5.00	0	39.02
40.00	PHYSICIAN LOANS	A	-266,368	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	ALCOHOL	A	-117	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	LOBBYING DUES	A	-18,662	ADMINISTRATIVE & GENERAL	5.00	0	40.02
40.03	HR DUES	A	-719	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04	ADMIN DUES	A	-3,974	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05	BOARD MEMBER EXPENSE	A	-2,600	ADMINISTRATIVE & GENERAL	5.00	0	40.05
40.06	HARRISBURG LLC	A	-1,165,173	RURAL HEALTH CLINIC IV	88.03	0	40.06
40.07	MARION LLC	A	-853,936	RURAL HEALTH CLINIC V	88.04	0	40.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,076,237				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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 12/17/2018 2:39 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,121,682	2,121,682	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	371,451	0	371,451	181,300	966	2.00
3.00	50.00	OPERATING ROOM	45,100	45,100	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	253,153	253,153	0	0	0	4.00
5.00	60.00	LABORATORY	12,000	0	12,000	260,300	60	5.00
6.00	65.00	RESPIRATORY THERAPY	26,792	26,792	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	62,432	62,432	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	21,242	21,242	0	0	0	8.00
9.00	91.00	EMERGENCY	2,284,300	2,244,300	40,000	211,500	325	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	25,591	0	25,591	211,500	197	10.00
200.00			5,223,743	4,774,701	449,042		1,548	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	15,044	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	84,200	4,210	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	7,509	375	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	33,047	1,652	0	0	0	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	20,032	1,002	0	0	0	10.00
200.00			144,788	7,239	15,044	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,121,682		1.00
2.00	40.00	SUBPROVIDER - IPF	0	84,200	287,251	287,251		2.00
3.00	50.00	OPERATING ROOM	0	0	0	45,100		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	253,153		4.00
5.00	60.00	LABORATORY	0	7,509	4,491	4,491		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	26,792		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	62,432		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	21,242		8.00
9.00	91.00	EMERGENCY	0	33,047	6,953	2,251,253		9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	0	20,032	5,559	5,559		10.00
200.00			0	144,788	304,254	5,078,955		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,137,852	1,137,852				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,739,684		1,739,684			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,591,444	6,792	7,510	7,605,746		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,067,195	224,543	451,651	1,192,410	8,935,799	5.00
7.00	00700	OPERATION OF PLANT	1,182,176	39,295	10,793	153,349	1,385,613	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	174,550	19,192	6,410	17,219	217,371	8.00
9.00	00900	HOUSEKEEPING	634,964	5,347	540	178,275	819,126	9.00
10.00	01000	DIETARY	862,608	35,118	7,581	208,547	1,113,854	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,554	0	139	35,671	146,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	482,928	8,599	18,041	91,287	600,855	14.00
15.00	01500	PHARMACY	579,820	16,837	46,975	192,746	836,378	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	794,320	11,750	24,138	178,037	1,008,245	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,605,478	147,064	106,208	1,007,104	4,865,854	30.00
40.00	04000	SUBPROVIDER - IPF	2,973,295	135,734	12,632	765,213	3,886,874	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,405	128,984	202,837	266,398	1,906,624	50.00
53.00	05300	ANESTHESIOLOGY	60,031	0	21,126	0	81,157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	737,752	57,519	152,982	183,126	1,131,379	54.00
54.01	05401	ULTRASOUND	217,757	7,269	57,036	65,838	347,900	54.01
54.02	03440	MAMMOGRAPHY	129,740	4,379	33,156	22,306	189,581	54.02
56.00	05600	RADIOISOTOPE	454,085	5,622	60,828	56,611	577,146	56.00
57.00	05700	CT SCAN	333,123	6,561	112,617	62,559	514,860	57.00
60.00	06000	LABORATORY	10,845,040	33,601	63,873	313,803	11,256,317	60.00
64.00	06400	INTRAVENOUS THERAPY	89	0	0	30	119	64.00
65.00	06500	RESPIRATORY THERAPY	729,926	13,383	21,065	200,763	965,137	65.00
66.00	06600	PHYSICAL THERAPY	602,900	5,868	8,076	194,775	811,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,652	0	1,902	55,858	230,412	67.00
68.00	06800	SPEECH PATHOLOGY	104,982	0	0	34,316	139,298	68.00
69.00	06900	ELECTROCARDIOLOGY	145,770	8,729	4,030	33,853	192,382	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	729,212	0	0	0	729,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,495,348	0	0	0	1,495,348	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,394,246	0	0	0	1,394,246	73.00
75.00	07500	ASC (NON-DISTINCT PART)	775,617	69,774	71,258	215,816	1,132,465	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	145,652	18,238	7,009	44,889	215,788	76.00
76.97	07697	CARDIAC REHABILITATION	97,992	14,206	1,139	31,594	144,931	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,028,007	0	27,614	525,109	2,580,730	88.00
88.01	08801	RURAL HEALTH CLINIC II	250,064	0	1,798	65,373	317,235	88.01
88.02	08802	RURAL HEALTH CLINIC III	288,713	0	7,768	69,509	365,990	88.02
88.03	08803	RURAL HEALTH CLINIC IV	110,279	0	5,227	25,385	140,891	88.03
88.04	08804	RURAL HEALTH CLINIC V	80,450	0	1,579	17,868	99,897	88.04
91.00	09100	EMERGENCY	1,309,306	104,112	41,671	373,721	1,828,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	449,889	0	5,203	131,053	586,145	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,933,895	1,128,516	1,602,412	7,010,411	53,191,952	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,149,259	0	136,343	565,664	2,851,266	192.00
194.00	07950	RETAIL 340B PHARMACY	252,504	0	0	0	252,504	194.00
194.01	07951	AUXILIARY	41,995	9,336	0	13,772	65,103	194.01
194.02	07952	FOUNDATION	156,929	0	929	15,899	173,757	194.02
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)	56,534,582	1,137,852	1,739,684	7,605,746	56,534,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 12/17/2018 2:39 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	8,935,799					5.00
7.00	00700	OPERATION OF PLANT	260,124	1,645,737				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,807	36,421	294,599			8.00
9.00	00900	HOUSEKEEPING	153,776	10,148	0	983,050		9.00
10.00	01000	DIETARY	209,106	66,645	0	0	1,389,605	10.00
11.00	01100	CAFETERIA	0	0	0	0	285,432	11.00
13.00	01300	NURSING ADMINISTRATION	27,477	0	0	14,609	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,800	16,318	0	0	0	14.00
15.00	01500	PHARMACY	157,015	31,951	0	12,303	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,280	22,297	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	913,477	279,084	80,636	355,236	294,855	30.00
40.00	04000	SUBPROVIDER - IPF	729,691	257,583	36,421	123,794	418,165	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357,934	244,775	31,259	18,454	0	50.00
53.00	05300	ANESTHESIOLOGY	15,236	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,396	109,154	16,155	0	0	54.00
54.01	05401	ULTRASOUND	65,312	13,795	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	35,590	8,310	0	0	0	54.02
56.00	05600	RADIOISOTOPE	108,349	10,669	0	0	0	56.00
57.00	05700	CT SCAN	96,656	12,451	0	0	0	57.00
60.00	06000	LABORATORY	2,113,154	63,765	0	19,607	0	60.00
64.00	06400	INTRAVENOUS THERAPY	22	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,187	25,396	9,618	11,918	0	65.00
66.00	06600	PHYSICAL THERAPY	152,367	11,135	9,838	13,456	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,256	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,151	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	36,116	16,565	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,725	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,745	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	212,600	132,412	28,892	82,273	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	40,510	34,611	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	27,208	26,960	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	484,486	0	27,446	117,643	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	59,555	0	13,282	20,376	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	68,708	0	10,487	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	26,450	0	1,829	4,613	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	18,754	0	1,096	2,307	0	88.04
91.00	09100	EMERGENCY	343,326	197,575	20,331	152,244	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	110,038	0	0	16,532	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,308,280	1,628,020	287,290	965,365	998,452	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	535,274	0	7,309	17,685	391,153	192.00
194.00	07950	RETAIL 340B PHARMACY	47,403	0	0	0	0	194.00
194.01	07951	AUXILIARY	12,222	17,717	0	0	0	194.01
194.02	07952	FOUNDATION	32,620	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,935,799	1,645,737	294,599	983,050	1,389,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 12/17/2018 2:39 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	285,432					11.00
13.00	01300	NURSING ADMINISTRATION	1,780	190,230				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,819	0	738,792			14.00
15.00	01500	PHARMACY	5,980	0	0	1,043,627		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,132	0	4,647	0	1,237,601	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,004	58,277	257,365	0	84,574	30.00
40.00	04000	SUBPROVIDER - IPF	48,642	47,239	35,949	0	87,914	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,551	22,872	111,345	0	40,005	50.00
53.00	05300	ANESTHESIOLOGY	0	0	12,362	0	30,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,171	0	2,406	0	37,030	54.00
54.01	05401	ULTRASOUND	4,566	0	3,290	0	32,261	54.01
54.02	03440	MAMMOGRAPHY	1,125	0	413	0	4,597	54.02
56.00	05600	RADIOISOTOPE	3,604	0	3,734	0	27,084	56.00
57.00	05700	CT SCAN	3,715	0	5,318	0	139,555	57.00
60.00	06000	LABORATORY	20,399	0	24,101	0	344,013	60.00
64.00	06400	INTRAVENOUS THERAPY	79	0	0	0	9,423	64.00
65.00	06500	RESPIRATORY THERAPY	10,694	0	8,019	0	62,352	65.00
66.00	06600	PHYSICAL THERAPY	8,452	0	1,533	0	21,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,170	0	51	0	7,224	67.00
68.00	06800	SPEECH PATHOLOGY	832	0	0	0	1,833	68.00
69.00	06900	ELECTROCARDIOLOGY	1,825	0	2,975	0	17,472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	17,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,402	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	819,658	74,810	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,865	15,407	72,594	0	37,938	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,772	1,720	13,954	0	3,788	76.00
76.97	07697	CARDIAC REHABILITATION	1,353	1,314	1,731	0	4,394	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,506	15,113	60,990	23,788	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,885	5,585	2,597	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,633	12,167	3,158	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,017	58,297	1,641	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	878	33,983	1,376	88.04
91.00	09100	EMERGENCY	17,514	17,009	136,149	0	94,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,120	7,886	7,287	0	6,309	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	275,164	190,230	726,749	990,680	1,237,601	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,486	0	11,221	52,947	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,103	0	79	0	0	194.01
194.02	07952	FOUNDATION	1,679	0	743	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	285,432	190,230	738,792	1,043,627	1,237,601	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,249,362	-390,116	6,859,246		30.00
40.00	04000	SUBPROVIDER - IPF	0	5,672,272	0	5,672,272		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,756,819	0	2,756,819		50.00
53.00	05300	ANESTHESIOLOGY	0	138,942	0	138,942		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,519,691	0	1,519,691		54.00
54.01	05401	ULTRASOUND	0	467,124	0	467,124		54.01
54.02	03440	MAMMOGRAPHY	0	239,616	0	239,616		54.02
56.00	05600	RADIOISOTOPE	0	730,586	0	730,586		56.00
57.00	05700	CT SCAN	0	772,555	0	772,555		57.00
60.00	06000	LABORATORY	0	13,841,356	0	13,841,356		60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,643	390,116	399,759		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,274,321	0	1,274,321		65.00
66.00	06600	PHYSICAL THERAPY	0	1,030,213	0	1,030,213		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	283,113	0	283,113		67.00
68.00	06800	SPEECH PATHOLOGY	0	168,114	0	168,114		68.00
69.00	06900	ELECTROCARDIOLOGY	0	267,335	0	267,335		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	883,475	0	883,475		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,794,475	0	1,794,475		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,550,459	0	2,550,459		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,730,446	0	1,730,446		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	312,143	0	312,143		76.00
76.97	07697	CARDIAC REHABILITATION	0	207,891	0	207,891		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,328,702	0	3,328,702		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	420,515	0	420,515		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	463,143	0	463,143		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	234,738	0	234,738		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	158,291	0	158,291		88.04
91.00	09100	EMERGENCY	0	2,807,654	0	2,807,654		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	742,317	0	742,317		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	52,055,311	0	52,055,311		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,874,341	0	3,874,341		192.00
194.00	07950	RETAIL 340B PHARMACY	0	299,907	0	299,907		194.00
194.01	07951	AUXILIARY	0	96,224	0	96,224		194.01
194.02	07952	FOUNDATION	0	208,799	0	208,799		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	56,534,582	0	56,534,582		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,792	7,510	14,302	14,302	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,341	224,543	451,651	699,535	2,249	5.00
7.00	00700	OPERATION OF PLANT	0	39,295	10,793	50,088	288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,192	6,410	25,602	32	8.00
9.00	00900	HOUSEKEEPING	0	5,347	540	5,887	335	9.00
10.00	01000	DIETARY	1,832	35,118	7,581	44,531	392	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	139	139	67	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,951	8,599	18,041	29,591	172	14.00
15.00	01500	PHARMACY	0	16,837	46,975	63,812	362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,750	24,138	35,888	335	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,706	147,064	106,208	258,978	1,892	30.00
40.00	04000	SUBPROVIDER - IPF	0	135,734	12,632	148,366	1,438	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,648	128,984	202,837	485,469	501	50.00
53.00	05300	ANESTHESIOLOGY	7,560	0	21,126	28,686	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,519	152,982	210,501	344	54.00
54.01	05401	ULTRASOUND	0	7,269	57,036	64,305	124	54.01
54.02	03440	MAMMOGRAPHY	0	4,379	33,156	37,535	42	54.02
56.00	05600	RADIOISOTOPE	0	5,622	60,828	66,450	106	56.00
57.00	05700	CT SCAN	0	6,561	112,617	119,178	118	57.00
60.00	06000	LABORATORY	0	33,601	63,873	97,474	590	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,356	13,383	21,065	59,804	377	65.00
66.00	06600	PHYSICAL THERAPY	1,800	5,868	8,076	15,744	366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,902	1,902	105	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	64	68.00
69.00	06900	ELECTROCARDIOLOGY	38,380	8,729	4,030	51,139	64	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	69,774	71,258	141,032	406	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	18,238	7,009	25,247	84	76.00
76.97	07697	CARDIAC REHABILITATION	0	14,206	1,139	15,345	59	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	150,265	0	27,614	177,879	987	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,080	0	1,798	23,878	123	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,493	0	7,768	27,261	131	88.02
88.03	08803	RURAL HEALTH CLINIC IV	7,887	0	5,227	13,114	48	88.03
88.04	08804	RURAL HEALTH CLINIC V	7,808	0	1,579	9,387	34	88.04
91.00	09100	EMERGENCY	0	104,112	41,671	145,783	702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	5,203	5,203	246	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	468,107	1,128,516	1,602,412	3,199,035	13,183	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	62,524	0	136,343	198,867	1,063	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	9,336	0	9,336	26	194.01
194.02	07952	FOUNDATION	0	0	929	929	30	194.02
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)	530,631	1,137,852	1,739,684	3,408,167	14,302	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/17/2018 2:39 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	701,784					5.00
7.00	00700	OPERATION OF PLANT	20,429	70,805				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,205	1,567	30,406			8.00
9.00	00900	HOUSEKEEPING	12,077	437	0	18,736		9.00
10.00	01000	DIETARY	16,423	2,867	0	0	64,213	10.00
11.00	01100	CAFETERIA	0	0	0	0	13,190	11.00
13.00	01300	NURSING ADMINISTRATION	2,158	0	0	278	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,859	702	0	0	0	14.00
15.00	01500	PHARMACY	12,332	1,375	0	234	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,866	959	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,742	12,006	8,324	6,772	13,625	30.00
40.00	04000	SUBPROVIDER - IPF	57,308	11,082	3,759	2,359	19,323	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,111	10,531	3,226	352	0	50.00
53.00	05300	ANESTHESIOLOGY	1,197	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,681	4,696	1,667	0	0	54.00
54.01	05401	ULTRASOUND	5,129	594	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	2,795	358	0	0	0	54.02
56.00	05600	RADIOISOTOPE	8,509	459	0	0	0	56.00
57.00	05700	CT SCAN	7,591	536	0	0	0	57.00
60.00	06000	LABORATORY	165,951	2,743	0	374	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,230	1,093	993	227	0	65.00
66.00	06600	PHYSICAL THERAPY	11,967	479	1,015	256	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,397	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,054	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,836	713	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,752	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,047	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,557	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	16,697	5,697	2,982	1,568	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,182	1,489	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,137	1,160	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,050	0	2,833	2,242	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,677	0	1,371	388	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,396	0	1,082	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,077	0	189	88	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,473	0	113	44	0	88.04
91.00	09100	EMERGENCY	26,964	8,500	2,098	2,902	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,642	0	0	315	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	652,500	70,043	29,652	18,399	46,138	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,039	0	754	337	18,075	192.00
194.00	07950	RETAIL 340B PHARMACY	3,723	0	0	0	0	194.00
194.01	07951	AUXILIARY	960	762	0	0	0	194.01
194.02	07952	FOUNDATION	2,562	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	701,784	70,805	30,406	18,736	64,213	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/17/2018 2:39 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	13,190					11.00
13.00	01300	NURSING ADMINISTRATION	82	2,724				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	408	0	39,732			14.00
15.00	01500	PHARMACY	276	0	0	78,391		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	607	0	250	0	52,905	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,772	833	13,843	0	3,620	30.00
40.00	04000	SUBPROVIDER - IPF	2,248	676	1,933	0	3,763	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,088	328	5,988	0	1,712	50.00
53.00	05300	ANESTHESIOLOGY	0	0	665	0	1,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	516	0	129	0	1,585	54.00
54.01	05401	ULTRASOUND	211	0	177	0	1,381	54.01
54.02	03440	MAMMOGRAPHY	52	0	22	0	197	54.02
56.00	05600	RADIOISOTOPE	167	0	201	0	1,159	56.00
57.00	05700	CT SCAN	172	0	286	0	5,974	57.00
60.00	06000	LABORATORY	943	0	1,296	0	14,658	60.00
64.00	06400	INTRAVENOUS THERAPY	4	0	0	0	403	64.00
65.00	06500	RESPIRATORY THERAPY	494	0	431	0	2,669	65.00
66.00	06600	PHYSICAL THERAPY	391	0	82	0	934	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	3	0	309	67.00
68.00	06800	SPEECH PATHOLOGY	38	0	0	0	78	68.00
69.00	06900	ELECTROCARDIOLOGY	84	0	160	0	748	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,567	3,202	73.00
75.00	07500	ASC (NON-DISTINCT PART)	733	221	3,904	0	1,624	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	82	25	750	0	162	76.00
76.97	07697	CARDIAC REHABILITATION	63	19	93	0	188	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	265	813	4,581	1,018	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	101	420	111	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	142	914	135	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	55	4,379	70	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	47	2,553	59	88.04
91.00	09100	EMERGENCY	809	244	7,322	0	4,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	375	113	392	0	270	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,715	2,724	39,085	74,414	52,905	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	346	0	603	3,977	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	51	0	4	0	0	194.01
194.02	07952	FOUNDATION	78	0	40	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,190	2,724	39,732	78,391	52,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		394,407	0	394,407		30.00
40.00	04000	SUBPROVIDER - IPF		252,255	0	252,255		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		537,306	0	537,306		50.00
53.00	05300	ANESTHESIOLOGY		31,840	0	31,840		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		236,119	0	236,119		54.00
54.01	05401	ULTRASOUND		71,921	0	71,921		54.01
54.02	03440	MAMMOGRAPHY		41,001	0	41,001		54.02
56.00	05600	RADIOISOTOPE		77,051	0	77,051		56.00
57.00	05700	CT SCAN		133,855	0	133,855		57.00
60.00	06000	LABORATORY		284,029	0	284,029		60.00
64.00	06400	INTRAVENOUS THERAPY		409	0	409		64.00
65.00	06500	RESPIRATORY THERAPY		80,318	0	80,318		65.00
66.00	06600	PHYSICAL THERAPY		31,234	0	31,234		66.00
67.00	06700	OCCUPATIONAL THERAPY		5,816	0	5,816		67.00
68.00	06800	SPEECH PATHOLOGY		2,234	0	2,234		68.00
69.00	06900	ELECTROCARDIOLOGY		55,744	0	55,744		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,495	0	11,495		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		22,835	0	22,835		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		85,326	0	85,326		73.00
75.00	07500	ASC (NON-DISTINCT PART)		174,864	0	174,864		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		31,021	0	31,021		76.00
76.97	07697	CARDIAC REHABILITATION		19,064	0	19,064		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		228,668	0	228,668		88.00
88.01	08801	RURAL HEALTH CLINIC II		31,069	0	31,069		88.01
88.02	08802	RURAL HEALTH CLINIC III		35,061	0	35,061		88.02
88.03	08803	RURAL HEALTH CLINIC IV		20,020	0	20,020		88.03
88.04	08804	RURAL HEALTH CLINIC V		13,710	0	13,710		88.04
91.00	09100	EMERGENCY		199,377	0	199,377		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		15,556	0	15,556		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,123,605	0	3,123,605		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		266,061	0	266,061		192.00
194.00	07950	RETAIL 340B PHARMACY		3,723	0	3,723		194.00
194.01	07951	AUXILIARY		11,139	0	11,139		194.01
194.02	07952	FOUNDATION		3,639	0	3,639		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,408,167	0	3,408,167		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/17/2018 2:39 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	78,733					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,685,610				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	470	7,277	22,830,306			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,537	437,611	3,579,304	-8,935,799	47,598,783	5.00
7.00	00700	OPERATION OF PLANT	2,719	10,458	460,309	0	1,385,613	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,328	6,211	51,686	0	217,371	8.00
9.00	00900	HOUSEKEEPING	370	523	535,131	0	819,126	9.00
10.00	01000	DIETARY	2,430	7,345	625,999	0	1,113,854	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	135	107,073	0	146,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	17,480	274,018	0	600,855	14.00
15.00	01500	PHARMACY	1,165	45,515	578,568	0	836,378	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	813	23,388	534,416	0	1,008,245	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,176	102,907	3,023,038	0	4,865,854	30.00
40.00	04000	SUBPROVIDER - IPF	9,392	12,239	2,296,950	0	3,886,874	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,925	196,532	799,652	0	1,906,624	50.00
53.00	05300	ANESTHESIOLOGY	0	20,469	0	0	81,157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,980	148,227	549,693	0	1,131,379	54.00
54.01	05401	ULTRASOUND	503	55,263	197,626	0	347,900	54.01
54.02	03440	MAMMOGRAPHY	303	32,125	66,957	0	189,581	54.02
56.00	05600	RADIOISOTOPE	389	58,937	169,929	0	577,146	56.00
57.00	05700	CT SCAN	454	109,117	187,784	0	514,860	57.00
60.00	06000	LABORATORY	2,325	61,888	941,947	0	11,256,317	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	89	0	119	64.00
65.00	06500	RESPIRATORY THERAPY	926	20,410	602,634	0	965,137	65.00
66.00	06600	PHYSICAL THERAPY	406	7,825	584,660	0	811,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,843	167,670	0	230,412	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	103,007	0	139,298	68.00
69.00	06900	ELECTROCARDIOLOGY	604	3,905	101,617	0	192,382	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	729,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,495,348	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,394,246	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,828	69,043	647,819	0	1,132,465	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,262	6,791	134,745	0	215,788	76.00
76.97	07697	CARDIAC REHABILITATION	983	1,104	94,836	0	144,931	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	26,756	1,576,226	0	2,580,730	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,742	196,232	0	317,235	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,527	208,646	0	365,990	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	5,065	76,198	0	140,891	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,530	53,634	0	99,897	88.04
91.00	09100	EMERGENCY	7,204	40,376	1,121,805	0	1,828,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,041	393,384	0	586,145	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,087	1,552,605	21,043,282	-8,935,799	44,256,153	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	132,105	1,697,961	0	2,851,266	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	252,504	194.00
194.01	07951	AUXILIARY	646	0	41,339	0	65,103	194.01
194.02	07952	FOUNDATION	0	900	47,724	0	173,757	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,137,852	1,739,684	7,605,746		8,935,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.452034	1.032080	0.333143		0.187732	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,302		701,784	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000626		0.014744	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
			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	60,007					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,328	45,426				8.00
9.00	00900	HOUSEKEEPING	370	0	2,557			9.00
10.00	01000	DIETARY	2,430	0	0	248,056		10.00
11.00	01100	CAFETERIA	0	0	0	50,952	694,100	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	38	0	4,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	0	0	0	21,446	14.00
15.00	01500	PHARMACY	1,165	0	32	0	14,543	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	813	0	0	0	31,933	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,176	12,434	924	52,634	145,915	30.00
40.00	04000	SUBPROVIDER - IPF	9,392	5,616	322	74,646	118,285	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,925	4,820	48	0	57,271	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,980	2,491	0	0	27,164	54.00
54.01	05401	ULTRASOUND	503	0	0	0	11,103	54.01
54.02	03440	MAMMOGRAPHY	303	0	0	0	2,736	54.02
56.00	05600	RADIOISOTOPE	389	0	0	0	8,765	56.00
57.00	05700	CT SCAN	454	0	0	0	9,035	57.00
60.00	06000	LABORATORY	2,325	0	51	0	49,606	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	192	64.00
65.00	06500	RESPIRATORY THERAPY	926	1,483	31	0	26,005	65.00
66.00	06600	PHYSICAL THERAPY	406	1,517	35	0	20,553	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	5,277	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,024	68.00
69.00	06900	ELECTROCARDIOLOGY	604	0	0	0	4,437	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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)	4,828	4,455	214	0	38,579	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,262	0	0	0	4,308	76.00
76.97	07697	CARDIAC REHABILITATION	983	0	0	0	3,291	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,232	306	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,048	53	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,617	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	282	12	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	169	6	0	0	88.04
91.00	09100	EMERGENCY	7,204	3,135	396	0	42,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	43	0	19,747	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,361	44,299	2,511	178,232	669,133	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,127	46	69,824	18,203	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	646	0	0	0	2,682	194.01
194.02	07952	FOUNDATION	0	0	0	0	4,082	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,645,737	294,599	983,050	1,389,605	285,432	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.425750	6.485251	384.454439	5.601981	0.411226	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,805	30,406	18,736	64,213	13,190	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.179946	0.669352	7.327337	0.258865	0.019003	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/17/2018 2:39 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	476,325					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	752,602				14.00
15.00	01500	PHARMACY	0	0	1,775,219			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,734	0	155,806,692		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145,915	262,176	0	10,647,674	0	30.00
40.00	04000	SUBPROVIDER - IPF	118,285	36,621	0	11,068,104	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,271	113,426	0	5,036,491	0	50.00
53.00	05300	ANESTHESIOLOGY	0	12,593	0	3,800,454	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,451	0	4,661,958	0	54.00
54.01	05401	ULTRASOUND	0	3,351	0	4,061,580	0	54.01
54.02	03440	MAMMOGRAPHY	0	421	0	578,728	0	54.02
56.00	05600	RADIOISOTOPE	0	3,804	0	3,409,852	0	56.00
57.00	05700	CT SCAN	0	5,417	0	17,569,532	0	57.00
60.00	06000	LABORATORY	0	24,552	0	43,306,352	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,186,366	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,169	0	7,849,882	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,562	0	2,746,235	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	52	0	909,515	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	230,815	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,031	0	2,199,661	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,186,394	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,316,793	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,394,246	9,418,323	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	38,579	73,951	0	4,776,312	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	4,308	14,215	0	476,956	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,291	1,763	0	553,222	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	46,339	15,396	103,744	2,994,853	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,920	9,500	326,976	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,682	20,696	397,595	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,036	99,164	206,596	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	894	57,805	173,183	0	88.04
91.00	09100	EMERGENCY	42,590	138,694	0	11,921,981	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	19,747	7,423	0	794,309	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	476,325	740,334	1,685,155	155,806,692	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,431	90,064	0	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	80	0	0	0	194.01
194.02	07952	FOUNDATION	0	757	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	190,230	738,792	1,043,627	1,237,601	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.399370	0.981650	0.587886	0.007943	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,724	39,732	78,391	52,905	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005719	0.052793	0.044158	0.000340	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-2 | Date/Time Prepared: 12/17/2018 2:39 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-390,116	7.00
8.00		IV THERAPY	1	64.00	390,116	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 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	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,859,246		6,859,246	0	6,859,246	30.00
40.00	04000	SUBPROVIDER - IPF	5,672,272		5,672,272	287,251	5,959,523	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,756,819		2,756,819	0	2,756,819	50.00
53.00	05300	ANESTHESIOLOGY	138,942		138,942	0	138,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,519,691		1,519,691	0	1,519,691	54.00
54.01	05401	ULTRASOUND	467,124		467,124	0	467,124	54.01
54.02	03440	MAMMOGRAPHY	239,616		239,616	0	239,616	54.02
56.00	05600	RADIOISOTOPE	730,586		730,586	0	730,586	56.00
57.00	05700	CT SCAN	772,555		772,555	0	772,555	57.00
60.00	06000	LABORATORY	13,841,356		13,841,356	4,491	13,845,847	60.00
64.00	06400	INTRAVENOUS THERAPY	399,759		399,759	0	399,759	64.00
65.00	06500	RESPIRATORY THERAPY	1,274,321	0	1,274,321	0	1,274,321	65.00
66.00	06600	PHYSICAL THERAPY	1,030,213	0	1,030,213	0	1,030,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	283,113	0	283,113	0	283,113	67.00
68.00	06800	SPEECH PATHOLOGY	168,114	0	168,114	0	168,114	68.00
69.00	06900	ELECTROCARDIOLOGY	267,335		267,335	0	267,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	883,475		883,475	0	883,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,794,475		1,794,475	0	1,794,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,550,459		2,550,459	0	2,550,459	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,730,446		1,730,446	0	1,730,446	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	312,143		312,143	0	312,143	76.00
76.97	07697	CARDIAC REHABILITATION	207,891		207,891	0	207,891	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,328,702		3,328,702	0	3,328,702	88.00
88.01	08801	RURAL HEALTH CLINIC II	420,515		420,515	0	420,515	88.01
88.02	08802	RURAL HEALTH CLINIC III	463,143		463,143	0	463,143	88.02
88.03	08803	RURAL HEALTH CLINIC IV	234,738		234,738	0	234,738	88.03
88.04	08804	RURAL HEALTH CLINIC V	158,291		158,291	0	158,291	88.04
91.00	09100	EMERGENCY	2,807,654		2,807,654	6,953	2,814,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,498,464		1,498,464		1,498,464	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	742,317		742,317		742,317	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,553,775	0	53,553,775	298,695	53,852,470	200.00
201.00		Less Observation Beds	1,498,464		1,498,464		1,498,464	201.00
202.00		Total (see instructions)	52,055,311	0	52,055,311	298,695	52,354,006	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,860,421		5,860,421			30.00
40.00	04000	SUBPROVIDER - IPF	11,068,104		11,068,104			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,330,411	3,706,080	5,036,491	0.547369	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	751,828	3,048,626	3,800,454	0.036559	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,775	4,154,183	4,661,958	0.325977	0.000000	54.00
54.01	05401	ULTRASOUND	772,837	3,288,743	4,061,580	0.115010	0.000000	54.01
54.02	03440	MAMMOGRAPHY	353	578,375	578,728	0.414039	0.000000	54.02
56.00	05600	RADIOISOTOPE	378,815	3,031,037	3,409,852	0.214257	0.000000	56.00
57.00	05700	CT SCAN	2,047,698	15,521,834	17,569,532	0.043971	0.000000	57.00
60.00	06000	LABORATORY	3,644,010	39,662,342	43,306,352	0.319615	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	493,489	692,877	1,186,366	0.336961	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,955,899	2,893,983	7,849,882	0.162336	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	590,322	2,155,913	2,746,235	0.375137	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	374,551	534,964	909,515	0.311279	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	131,174	99,641	230,815	0.728350	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	396,125	1,803,536	2,199,661	0.121535	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,045,981	1,140,413	2,186,394	0.404079	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,489,204	827,589	2,316,793	0.774551	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,586,873	5,831,450	9,418,323	0.270798	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	205,496	4,570,816	4,776,312	0.362298	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,512	474,444	476,956	0.654448	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	553,222	553,222	0.375782	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,994,853	2,994,853			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	326,976	326,976			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	397,595	397,595			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	206,596	206,596			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	173,183	173,183			88.04
91.00	09100	EMERGENCY	1,403,301	10,518,680	11,921,981	0.235502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,336,418	3,450,835	4,787,253	0.313011	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	794,309	794,309			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,373,597	113,433,095	155,806,692			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,373,597	113,433,095	155,806,692			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 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
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.547369		50.00
53.00	05300	ANESTHESIOLOGY	0.036559		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977		54.00
54.01	05401	ULTRASOUND	0.115010		54.01
54.02	03440	MAMMOGRAPHY	0.414039		54.02
56.00	05600	RADIOISOTOPE	0.214257		56.00
57.00	05700	CT SCAN	0.043971		57.00
60.00	06000	LABORATORY	0.319719		60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961		64.00
65.00	06500	RESPIRATORY THERAPY	0.162336		65.00
66.00	06600	PHYSICAL THERAPY	0.375137		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279		67.00
68.00	06800	SPEECH PATHOLOGY	0.728350		68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448		76.00
76.97	07697	CARDIAC REHABILITATION	0.375782		76.97
		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	08804	RURAL HEALTH CLINIC V			88.04
91.00	09100	EMERGENCY	0.236086		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 pm

Title XIX | Hospital

		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	6,859,246		6,859,246	0	6,859,246	30.00
40.00	04000	SUBPROVIDER - IPF	5,672,272		5,672,272	287,251	5,959,523	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,756,819		2,756,819	0	2,756,819	50.00
53.00	05300	ANESTHESIOLOGY	138,942		138,942	0	138,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,519,691		1,519,691	0	1,519,691	54.00
54.01	05401	ULTRASOUND	467,124		467,124	0	467,124	54.01
54.02	03440	MAMMOGRAPHY	239,616		239,616	0	239,616	54.02
56.00	05600	RADIOISOTOPE	730,586		730,586	0	730,586	56.00
57.00	05700	CT SCAN	772,555		772,555	0	772,555	57.00
60.00	06000	LABORATORY	13,841,356		13,841,356	4,491	13,845,847	60.00
64.00	06400	INTRAVENOUS THERAPY	399,759		399,759	0	399,759	64.00
65.00	06500	RESPIRATORY THERAPY	1,274,321	0	1,274,321	0	1,274,321	65.00
66.00	06600	PHYSICAL THERAPY	1,030,213	0	1,030,213	0	1,030,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	283,113	0	283,113	0	283,113	67.00
68.00	06800	SPEECH PATHOLOGY	168,114	0	168,114	0	168,114	68.00
69.00	06900	ELECTROCARDIOLOGY	267,335		267,335	0	267,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	883,475		883,475	0	883,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,794,475		1,794,475	0	1,794,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,550,459		2,550,459	0	2,550,459	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,730,446		1,730,446	0	1,730,446	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	312,143		312,143	0	312,143	76.00
76.97	07697	CARDIAC REHABILITATION	207,891		207,891	0	207,891	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,328,702		3,328,702	0	3,328,702	88.00
88.01	08801	RURAL HEALTH CLINIC II	420,515		420,515	0	420,515	88.01
88.02	08802	RURAL HEALTH CLINIC III	463,143		463,143	0	463,143	88.02
88.03	08803	RURAL HEALTH CLINIC IV	234,738		234,738	0	234,738	88.03
88.04	08804	RURAL HEALTH CLINIC V	158,291		158,291	0	158,291	88.04
91.00	09100	EMERGENCY	2,807,654		2,807,654	6,953	2,814,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,498,464		1,498,464		1,498,464	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	742,317		742,317		742,317	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,553,775	0	53,553,775	298,695	53,852,470	200.00
201.00		Less Observation Beds	1,498,464		1,498,464		1,498,464	201.00
202.00		Total (see instructions)	52,055,311	0	52,055,311	298,695	52,354,006	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 pm

Title XIX | Hospital

		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	5,860,421		5,860,421			30.00
40.00	04000	SUBPROVIDER - IPF	11,068,104		11,068,104			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,330,411	3,706,080	5,036,491	0.547369	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	751,828	3,048,626	3,800,454	0.036559	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	507,775	4,154,183	4,661,958	0.325977	0.000000	54.00
54.01	05401	ULTRASOUND	772,837	3,288,743	4,061,580	0.115010	0.000000	54.01
54.02	03440	MAMMOGRAPHY	353	578,375	578,728	0.414039	0.000000	54.02
56.00	05600	RADIOISOTOPE	378,815	3,031,037	3,409,852	0.214257	0.000000	56.00
57.00	05700	CT SCAN	2,047,698	15,521,834	17,569,532	0.043971	0.000000	57.00
60.00	06000	LABORATORY	3,644,010	39,662,342	43,306,352	0.319615	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	493,489	692,877	1,186,366	0.336961	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,955,899	2,893,983	7,849,882	0.162336	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	590,322	2,155,913	2,746,235	0.375137	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	374,551	534,964	909,515	0.311279	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	131,174	99,641	230,815	0.728350	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	396,125	1,803,536	2,199,661	0.121535	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,045,981	1,140,413	2,186,394	0.404079	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,489,204	827,589	2,316,793	0.774551	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,586,873	5,831,450	9,418,323	0.270798	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	205,496	4,570,816	4,776,312	0.362298	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,512	474,444	476,956	0.654448	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	553,222	553,222	0.375782	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,994,853	2,994,853	1.111474	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	326,976	326,976	1.286073	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	397,595	397,595	1.164861	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	206,596	206,596	1.136218	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	173,183	173,183	0.914010	0.000000	88.04
91.00	09100	EMERGENCY	1,403,301	10,518,680	11,921,981	0.235502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,336,418	3,450,835	4,787,253	0.313011	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	794,309	794,309			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,373,597	113,433,095	155,806,692			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,373,597	113,433,095	155,806,692			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 12/17/2018 2:39 pm

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
54.02	03440	MAMMOGRAPHY	0.000000		54.02
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	03950	FAITH CENTER CHEMOTHERAPY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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	08804	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			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	394,407	1,783	392,624	7,054	55.66	30.00
40.00	SUBPROVIDER - IPF	252,255	0	252,255	8,806	28.65	40.00
200.00	Total (lines 30 through 199)	646,662		644,879	15,860		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	3,559	198,094				30.00
40.00	SUBPROVIDER - IPF	2,709	77,613				40.00
200.00	Total (lines 30 through 199)	6,268	275,707				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,306	5,036,491	0.106683	658,500	70,251	50.00
53.00	05300	ANESTHESIOLOGY	31,840	3,800,454	0.008378	379,847	3,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,119	4,661,958	0.050648	483,112	24,469	54.00
54.01	05401	ULTRASOUND	71,921	4,061,580	0.017708	693,985	12,289	54.01
54.02	03440	MAMMOGRAPHY	41,001	578,728	0.070847	0	0	54.02
56.00	05600	RADIOISOTOPE	77,051	3,409,852	0.022597	301,101	6,804	56.00
57.00	05700	CT SCAN	133,855	17,569,532	0.007619	1,916,607	14,603	57.00
60.00	06000	LABORATORY	284,029	43,306,352	0.006559	3,327,885	21,828	60.00
64.00	06400	INTRAVENOUS THERAPY	409	1,186,366	0.000345	254,963	88	64.00
65.00	06500	RESPIRATORY THERAPY	80,318	7,849,882	0.010232	3,612,340	36,961	65.00
66.00	06600	PHYSICAL THERAPY	31,234	2,746,235	0.011373	382,931	4,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,816	909,515	0.006395	259,932	1,662	67.00
68.00	06800	SPEECH PATHOLOGY	2,234	230,815	0.009679	105,033	1,017	68.00
69.00	06900	ELECTROCARDIOLOGY	55,744	2,199,661	0.025342	374,979	9,503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,495	2,186,394	0.005258	709,551	3,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,835	2,316,793	0.009856	752,237	7,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,326	9,418,323	0.009060	1,738,217	15,748	73.00
75.00	07500	ASC (NON-DISTINCT PART)	174,864	4,776,312	0.036611	133,288	4,880	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	31,021	476,956	0.065040	1,930	126	76.00
76.97	07697	CARDIAC REHABILITATION	19,064	553,222	0.034460	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	228,668	2,994,853	0.076354	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,069	326,976	0.095019	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,061	397,595	0.088183	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	20,020	206,596	0.096904	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	13,710	173,183	0.079165	0	0	88.04
91.00	09100	EMERGENCY	199,377	11,921,981	0.016723	1,260,990	21,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	86,162	4,787,253	0.017998	644,939	11,608	92.00
200.00		Total (lines 50 through 199)	2,547,549	138,083,858		17,992,367	271,607	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	7,054	0.00	3,559	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	8,806	0.00	2,709	40.00
200.00		Total (lines 30 through 199)		0	15,860		6,268	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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	08804	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	5,036,491	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,800,454	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,661,958	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,061,580	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	578,728	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	3,409,852	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,569,532	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	43,306,352	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,186,366	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,849,882	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,746,235	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	909,515	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	230,815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,199,661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,186,394	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,316,793	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,418,323	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,776,312	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	476,956	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	553,222	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,994,853	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	326,976	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	397,595	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	206,596	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	173,183	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	11,921,981	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,787,253	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	138,083,858		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | 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	658,500	0	1,111,837	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	379,847	0	1,055,567	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	483,112	0	1,149,332	0	54.00
54.01	05401	ULTRASOUND	0.000000	693,985	0	1,197,660	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	301,101	0	1,378,662	0	56.00
57.00	05700	CT SCAN	0.000000	1,916,607	0	4,962,079	0	57.00
60.00	06000	LABORATORY	0.000000	3,327,885	0	2,994,988	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	254,963	0	185,385	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,612,340	0	763,282	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	382,931	0	15,114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	259,932	0	6,763	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	105,033	0	2,843	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	374,979	0	672,826	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	709,551	0	340,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	752,237	0	319,659	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,738,217	0	2,551,117	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	133,288	0	1,920,613	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	1,930	0	250,639	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	197,154	0	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	1,260,990	0	2,683,436	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	644,939	0	823,830	0	92.00
200.00		Total (lines 50 through 199)		17,992,367	0	24,583,570	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.547369	1,111,837	0	0	608,585	50.00
53.00	05300	ANESTHESIOLOGY	0.036559	1,055,567	0	0	38,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977	1,149,332	0	0	374,656	54.00
54.01	05401	ULTRASOUND	0.115010	1,197,660	0	0	137,743	54.01
54.02	03440	MAMMOGRAPHY	0.414039	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.214257	1,378,662	0	0	295,388	56.00
57.00	05700	CT SCAN	0.043971	4,962,079	0	0	218,188	57.00
60.00	06000	LABORATORY	0.319615	2,994,988	1	0	957,243	60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961	185,385	0	0	62,468	64.00
65.00	06500	RESPIRATORY THERAPY	0.162336	763,282	0	0	123,908	65.00
66.00	06600	PHYSICAL THERAPY	0.375137	15,114	0	0	5,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279	6,763	0	0	2,105	67.00
68.00	06800	SPEECH PATHOLOGY	0.728350	2,843	0	0	2,071	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535	672,826	0	0	81,772	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079	340,784	0	0	137,704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551	319,659	0	0	247,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798	2,551,117	0	4,562	690,837	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298	1,920,613	0	0	695,834	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448	250,639	0	0	164,030	76.00
76.97	07697	CARDIAC REHABILITATION	0.375782	197,154	0	0	74,087	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.235502	2,683,436	0	561	631,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011	823,830	0	0	257,868	92.00
200.00		Subtotal (see instructions)		24,583,570	1	5,123	5,808,294	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		24,583,570	1	5,123	5,808,294	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,235		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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	08804	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	0	132		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,367		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,367		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 12/17/2018 2:39 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	537,306	5,036,491	0.106683	0	0	50.00
53.00	05300	ANESTHESIOLOGY	31,840	3,800,454	0.008378	3,336	28	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,119	4,661,958	0.050648	21,291	1,078	54.00
54.01	05401	ULTRASOUND	71,921	4,061,580	0.017708	3,881	69	54.01
54.02	03440	MAMMOGRAPHY	41,001	578,728	0.070847	0	0	54.02
56.00	05600	RADIOISOTOPE	77,051	3,409,852	0.022597	0	0	56.00
57.00	05700	CT SCAN	133,855	17,569,532	0.007619	95,966	731	57.00
60.00	06000	LABORATORY	284,029	43,306,352	0.006559	303,089	1,988	60.00
64.00	06400	INTRAVENOUS THERAPY	409	1,186,366	0.000345	1,060	0	64.00
65.00	06500	RESPIRATORY THERAPY	80,318	7,849,882	0.010232	219,401	2,245	65.00
66.00	06600	PHYSICAL THERAPY	31,234	2,746,235	0.011373	18,587	211	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,816	909,515	0.006395	302	2	67.00
68.00	06800	SPEECH PATHOLOGY	2,234	230,815	0.009679	446	4	68.00
69.00	06900	ELECTROCARDIOLOGY	55,744	2,199,661	0.025342	19,831	503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,495	2,186,394	0.005258	23,741	125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,835	2,316,793	0.009856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,326	9,418,323	0.009060	421,307	3,817	73.00
75.00	07500	ASC (NON-DISTINCT PART)	174,864	4,776,312	0.036611	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	31,021	476,956	0.065040	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	19,064	553,222	0.034460	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	228,668	2,994,853	0.076354	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,069	326,976	0.095019	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,061	397,595	0.088183	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	20,020	206,596	0.096904	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	13,710	173,183	0.079165	0	0	88.04
91.00	09100	EMERGENCY	199,377	11,921,981	0.016723	120,794	2,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,787,253	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,461,387	138,083,858		1,253,032	12,821	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 12/17/2018 2:39 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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	08804	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: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	5,036,491	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,800,454	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,661,958	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,061,580	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	578,728	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	3,409,852	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,569,532	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	43,306,352	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,186,366	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,849,882	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,746,235	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	909,515	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	230,815	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,199,661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,186,394	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,316,793	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,418,323	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,776,312	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	476,956	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	553,222	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,994,853	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	326,976	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	397,595	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	206,596	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	173,183	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	11,921,981	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,787,253	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	138,083,858		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/17/2018 2:39 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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,336	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,291	0	509	0	54.00
54.01	05401	ULTRASOUND	0.000000	3,881	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	95,966	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	303,089	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,060	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	219,401	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	18,587	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	302	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	446	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	19,831	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23,741	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	421,307	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
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	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	120,794	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)		1,253,032	0	509	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.547369	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.036559	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977	509	0	0	166	54.00
54.01	05401	ULTRASOUND	0.115010	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.414039	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.214257	0	0	0	0	56.00
57.00	05700	CT SCAN	0.043971	0	0	0	0	57.00
60.00	06000	LABORATORY	0.319615	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.162336	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.375137	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.728350	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798	0	0	35	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.375782	0	0	0	0	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.235502	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011	0	0	0	0	92.00
200.00		Subtotal (see instructions)		509	0	35	166	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		509	0	35	166	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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	08804	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	9		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,210	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,054	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)	5,506	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	62	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)	41	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	26	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)	27	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,559	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)	62	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)	41	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	218.85	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	224.47	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,859,246	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)	13,569	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)	9,203	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,041	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	4,196	25.00
26.00	Total swing-bed cost (see instructions)	31,009	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,828,237	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)	6,828,237	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)	968.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,445,112	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)	3,445,112	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,732,561	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,177,673	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)	198,094	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	271,607	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	469,701	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,707,972	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)	13,569	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	9,203	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	22,772	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)	1,548	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	968.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,498,464	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	394,407	6,859,246	0.057500	1,498,464	86,162	90.00
91.00	Nursing School cost	0	6,859,246	0.000000	1,498,464	0	91.00
92.00	Allied health cost	0	6,859,246	0.000000	1,498,464	0	92.00
93.00	All other Medical Education	0	6,859,246	0.000000	1,498,464	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 12/17/2018 2:39 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)	8,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,806	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)	8,806	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)	2,709	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)	5,959,523	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)	5,959,523	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)	5,959,523	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)	676.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,833,343	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)	1,833,343	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/17/2018 2:39 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	306,607	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,139,950	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)	77,613	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,821	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	90,434	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,049,516	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1

Component CCN: 14-S210 | Date/Time Prepared: 12/17/2018 2:39 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	252,255	5,959,523	0.042328	0	0	90.00
91.00	Nursing School cost	0	5,959,523	0.000000	0	0	91.00
92.00	Allied health cost	0	5,959,523	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,959,523	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,834,390		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.547369	658,500	360,442	50.00
53.00	05300	ANESTHESIOLOGY	0.036559	379,847	13,887	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977	483,112	157,483	54.00
54.01	05401	ULTRASOUND	0.115010	693,985	79,815	54.01
54.02	03440	MAMMOGRAPHY	0.414039	0	0	54.02
56.00	05600	RADIOISOTOPE	0.214257	301,101	64,513	56.00
57.00	05700	CT SCAN	0.043971	1,916,607	84,275	57.00
60.00	06000	LABORATORY	0.319719	3,327,885	1,063,988	60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961	254,963	85,913	64.00
65.00	06500	RESPIRATORY THERAPY	0.162336	3,612,340	586,413	65.00
66.00	06600	PHYSICAL THERAPY	0.375137	382,931	143,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279	259,932	80,911	67.00
68.00	06800	SPEECH PATHOLOGY	0.728350	105,033	76,501	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535	374,979	45,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079	709,551	286,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551	752,237	582,646	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798	1,738,217	470,706	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298	133,288	48,290	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448	1,930	1,263	76.00
76.97	07697	CARDIAC REHABILITATION	0.375782	0	0	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.236086	1,260,990	297,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011	644,939	201,873	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,992,367	4,732,561	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)		17,992,367		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 12/17/2018 2:39 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
40.00	04000	SUBPROVIDER - IPF		3,424,691		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.547369	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.036559	3,336	122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977	21,291	6,940	54.00
54.01	05401	ULTRASOUND	0.115010	3,881	446	54.01
54.02	03440	MAMMOGRAPHY	0.414039	0	0	54.02
56.00	05600	RADIOISOTOPE	0.214257	0	0	56.00
57.00	05700	CT SCAN	0.043971	95,966	4,220	57.00
60.00	06000	LABORATORY	0.319719	303,089	96,903	60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961	1,060	357	64.00
65.00	06500	RESPIRATORY THERAPY	0.162336	219,401	35,617	65.00
66.00	06600	PHYSICAL THERAPY	0.375137	18,587	6,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279	302	94	67.00
68.00	06800	SPEECH PATHOLOGY	0.728350	446	325	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535	19,831	2,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079	23,741	9,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798	421,307	114,089	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.375782	0	0	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.236086	120,794	28,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,253,032	306,607	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)		1,253,032		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3

Component CCN: 14-U210 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.547369	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.036559	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325977	1,374	448	54.00
54.01	05401	ULTRASOUND	0.115010	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.414039	0	0	54.02
56.00	05600	RADIOISOTOPE	0.214257	0	0	56.00
57.00	05700	CT SCAN	0.043971	0	0	57.00
60.00	06000	LABORATORY	0.319615	9,710	3,103	60.00
64.00	06400	INTRAVENOUS THERAPY	0.336961	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.162336	56,660	9,198	65.00
66.00	06600	PHYSICAL THERAPY	0.375137	33,110	12,421	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311279	24,947	7,765	67.00
68.00	06800	SPEECH PATHOLOGY	0.728350	4,358	3,174	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121535	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404079	6,804	2,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.774551	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270798	20,283	5,493	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.362298	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.654448	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.375782	0	0	76.97
		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	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.235502	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.313011	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		157,246	44,351	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)		157,246		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 12/17/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,364,609	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,416,410	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)	0	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)	33.33	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 that 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)	7.89	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.51	31.00
32.00	Sum of lines 30 and 31	25.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.17	33.00
34.00	Disproportionate share adjustment (see instructions)	146,982	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000015466	0.000028412	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	92,448	192,255	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	23,302	143,796	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	167,098		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)	6,095,099		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,928,572		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,928,572	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		470,815	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		7,399,387	59.00
60.00	Primary payer payments		684	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,398,703	61.00
62.00	Deductibles billed to program beneficiaries		969,344	62.00
63.00	Coinsurance billed to program beneficiaries		8,997	63.00
64.00	Allowable bad debts (see instructions)		257,986	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		167,691	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		243,934	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,588,053	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)		25,482	70.93
70.94	HRR adjustment amount (see instructions)		-102,458	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 12/17/2018 2:39 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)	2017	133,239	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	576,934	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,221,250	71.00
71.01	Sequestration adjustment (see instructions)		144,425	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,947,431	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)		129,394	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,364,609	0	1,364,609		1,364,609	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,416,410	0		4,416,410	4,416,410	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1017	0.1017	0.1017	0.1017		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	146,982	0	34,695	112,287	146,982	11.00
11.01	Uncompensated care payments	36.00	167,098	0	23,302	143,796	167,098	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,095,099	0	1,422,606	4,672,493	6,095,099	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,928,572	0	1,602,375	5,326,197	6,928,572	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,928,572	0	1,602,375	5,326,197	6,928,572	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	470,815	0	108,956	361,859	470,815	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,711,331	5,688,056	7,399,387	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	470,815	0	108,956	361,859	470,815	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	470,815	0	108,956	361,859	470,815	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.077857	0.101429		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			133,239		133,239	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				576,934	576,934	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 12/17/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,367	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,808,294	2.00
3.00	OPPS payments	5,085,376	3.00
4.00	Outlier payment (see instructions)	4,042	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.850	5.00
6.00	Line 2 times line 5	4,937,050	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)	1,367	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,124	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)	5,124	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)	5,124	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,757	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)	1,367	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)	5,089,418	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,035,973	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,054,812	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,054,812	30.00
31.00	Primary payer payments	69	31.00
32.00	Subtotal (line 30 minus line 31)	4,054,743	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)	341,180	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	221,767	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	319,774	36.00
37.00	Subtotal (see instructions)	4,276,510	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)	4,276,510	40.00
40.01	Sequestration adjustment (see instructions)	85,530	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,191,366	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-386	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 12/17/2018 2:39 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	166	2.00
3.00	OPPS payments	54	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	35	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)	35	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)	35	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	26	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)	9	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)	54	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	11	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)	52	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)	52	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	52	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	52	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)	52	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	49	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	2	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,947,431		4,191,366	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)		6,947,431		4,191,366	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		129,394		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		386	6.02
7.00	Total Medicare program liability (see instructions)		7,076,825		4,190,980	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: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 12/17/2018 2:39 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		2,248,094		49	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)		2,248,094		49	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		13,220		2	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,261,314		51	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: 14-0210 | Component CCN: 14-U210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		31,805		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)		31,805		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		31,805		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: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 12/17/2018 2:39 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 - SWING BEDS | Provider CCN: 14-0210 | Component CCN: 14-U210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	32,454	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	103	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	32,454	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	32,454	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	32,454	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	32,454	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	32,454	0	19.00
19.01	Sequestration adjustment (see instructions)	649	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	31,805	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 12/17/2018 2:39 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)	2,435,877	1.00
2.00	Net IPF PPS Outlier Payments	1,626	2.00
3.00	Net IPF PPS ECT Payments	1,762	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)	24.126027	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)	2,439,265	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)	2,439,265	16.00
17.00	Primary payer payments	1,321	17.00
18.00	Subtotal (line 16 less line 17).	2,437,944	18.00
19.00	Deductibles	248,252	19.00
20.00	Subtotal (line 18 minus line 19)	2,189,692	20.00
21.00	Coinsurance	5,665	21.00
22.00	Subtotal (line 20 minus line 21)	2,184,027	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	189,901	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	123,436	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	144,246	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,307,463	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)	2,307,463	31.00
31.01	Sequestration adjustment (see instructions)	46,149	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,248,094	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)	13,220	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	1,626	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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 12/17/2018 2:39 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,119,951	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,983,176	0	0	0	4.00
5.00	Other receivable	239,035	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,393,404	0	0	0	7.00
8.00	Prepaid expenses	868,923	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)	17,604,489	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	818,193	0	0	0	12.00
13.00	Land improvements	923,803	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	37,234,430	0	0	0	15.00
16.00	Accumulated depreciation	-26,605,999	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,495,739	0	0	0	23.00
24.00	Accumulated depreciation	0	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	180,568	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,046,734	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,737,713	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	269,277	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,006,990	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,658,213	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,319,179	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,332,190	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	911,557	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	0	0	0	0	43.00
44.00	Other current liabilities	4,723,988	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,286,914	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	19,608,401	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,608,401	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,895,315	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,762,898				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,762,898	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,658,213	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 12/17/2018 2:39 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		26,095,789		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,301,431				2.00
3.00	Total (sum of line 1 and line 2)		20,794,358		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)		20,794,358		0		11.00
12.00	FOUNDATION LOSS FOR CONSOLIDATED AFS	31,460		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)		31,460		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,762,898		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	FOUNDATION LOSS FOR CONSOLIDATED AFS		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: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 12/17/2018 2:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,777,741		5,777,741	1.00
2.00	SUBPROVIDER - IPF	11,068,104		11,068,104	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	54,590		54,590	5.00
6.00	Swing bed - NF	28,090		28,090	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,928,525		16,928,525	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,928,525		16,928,525	17.00
18.00	Ancillary services	22,705,353	94,570,068	117,275,421	18.00
19.00	Outpatient services	2,739,719	13,969,515	16,709,234	19.00
20.00	RURAL HEALTH CLINIC	0	2,994,853	2,994,853	20.00
20.01	RURAL HEALTH CLINIC II	0	326,976	326,976	20.01
20.02	RURAL HEALTH CLINIC III	0	397,595	397,595	20.02
20.03	RURAL HEALTH CLINIC IV	0	206,596	206,596	20.03
20.04	RURAL HEALTH CLINIC V	0	173,183	173,183	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		794,309	794,309	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES AND PHY PRIVATE OFFICE	2,168,055	18,547,653	20,715,708	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	44,541,652	131,980,748	176,522,400	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,610,819		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)		67,610,819		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 12/17/2018 2:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	176,522,400	1.00
2.00	Less contractual allowances and discounts on patients' accounts	113,543,079	2.00
3.00	Net patient revenues (line 1 minus line 2)	62,979,321	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,610,819	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,631,498	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,270	6.00
7.00	Income from investments	286,599	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	544	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	116,085	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	609	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	5,497	21.00
22.00	Rental of hospital space	94,825	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	520,498	24.00
24.01	340B CONTRACT RETAIL PHARMACY INCOME	455,978	24.01
25.00	Total other income (sum of lines 6-24)	1,483,905	25.00
26.00	Total (line 5 plus line 25)	-3,147,593	26.00
27.00	LOSS ON DISPOSAL OF ASSET	35,851	27.00
27.01	PROVISION FOR INCOME TAXES	2,117,987	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	2,153,838	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,301,431	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H | Date/Time Prepared: 12/17/2018 2:39 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	129,156	0	0	4,423	14,850	148,429	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	225,395	0	23,755	0	0	249,150	6.00
7.00	Physical Therapy	88,411	0	14,870	0	0	103,281	7.00
8.00	Occupational Therapy	2,042	0	469	0	0	2,511	8.00
9.00	Speech Pathology	3,139	0	458	0	0	3,597	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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)	448,143	0	39,552	4,423	14,850	506,968	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	-57,079	91,350	0	91,350			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	249,150	0	249,150			6.00
7.00	Physical Therapy	0	103,281	0	103,281			7.00
8.00	Occupational Therapy	0	2,511	0	2,511			8.00
9.00	Speech Pathology	0	3,597	0	3,597			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			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)	-57,079	449,889	0	449,889			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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	91,350	0	0	0	0	91,350	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	249,150	0	0	0	0	249,150	6.00
7.00	Physical Therapy	103,281	0	0	0	0	103,281	7.00
8.00	Occupational Therapy	2,511	0	0	0	0	2,511	8.00
9.00	Speech Pathology	3,597	0	0	0	0	3,597	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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)	449,889	0	0	0	0	449,889	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	91,350		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	63,480	312,630	6.00
7.00	Physical Therapy	26,314	129,595	7.00
8.00	Occupational Therapy	640	3,151	8.00
9.00	Speech Pathology	916	4,513	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	0	0	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)		449,889	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 12/17/2018 2:39 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-91,350	358,539	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	249,150	6.00
7.00	Physical Therapy	0	0	0	0	0	103,281	7.00
8.00	Occupational Therapy	0	0	0	0	0	2,511	8.00
9.00	Speech Pathology	0	0	0	0	0	3,597	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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	-91,350	358,539	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		91,350	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.254784	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	5,203	24,785	29,988	5,630	1.00
2.00	Skilled Nursing Care	312,630	0	0	75,088	387,718	72,786	2.00
3.00	Physical Therapy	129,595	0	0	29,454	159,049	29,859	3.00
4.00	Occupational Therapy	3,151	0	0	680	3,831	719	4.00
5.00	Speech Pathology	4,513	0	0	1,046	5,559	1,044	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)	449,889	0	5,203	131,053	586,145	110,038	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	0	0	16,532	0	1,234	1,198	1.00
2.00	Skilled Nursing Care	0	0	0	0	4,803	4,665	2.00
3.00	Physical Therapy	0	0	0	0	1,967	1,910	3.00
4.00	Occupational Therapy	0	0	0	0	47	46	4.00
5.00	Speech Pathology	0	0	0	0	69	67	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)	0	0	16,532	0	8,120	7,886	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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 12/17/2018 2:39 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	7,287	0	6,309	0	68,178	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	469,972	0	2.00
3.00	Physical Therapy	0	0	0	0	192,785	0	3.00
4.00	Occupational Therapy	0	0	0	0	4,643	0	4.00
5.00	Speech Pathology	0	0	0	0	6,739	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)	7,287	0	6,309	0	742,317	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	68,178						1.00
2.00	Skilled Nursing Care	469,972	47,529	517,501				2.00
3.00	Physical Therapy	192,785	19,497	212,282				3.00
4.00	Occupational Therapy	4,643	470	5,113				4.00
5.00	Speech Pathology	6,739	682	7,421				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	742,317	68,178	742,317				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.		0.101133					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: 14-0210 HHA CCN: 14-7419

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

Worksheet H-2 Part II Date/Time Prepared: 12/17/2018 2:39 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	0	5,041	74,397	0	29,988	0	1.00
2.00	Skilled Nursing Care	0	0	225,395	0	387,718	0	2.00
3.00	Physical Therapy	0	0	88,411	0	159,049	0	3.00
4.00	Occupational Therapy	0	0	2,042	0	3,831	0	4.00
5.00	Speech Pathology	0	0	3,139	0	5,559	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	5,041	393,384		586,145	0	20.00
21.00	Total cost to be allocated	0	5,203	131,053		110,038	0	21.00
22.00	Unit cost multiplier	0.000000	1.032136	0.333143		0.187732	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	43	0	3,000	3,000	7,423	1.00
2.00	Skilled Nursing Care	0	0	0	11,682	11,682	0	2.00
3.00	Physical Therapy	0	0	0	4,783	4,783	0	3.00
4.00	Occupational Therapy	0	0	0	115	115	0	4.00
5.00	Speech Pathology	0	0	0	167	167	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	43	0	19,747	19,747	7,423	20.00
21.00	Total cost to be allocated	0	16,532	0	8,120	7,886	7,287	21.00
22.00	Unit cost multiplier	0.000000	384.465116	0.000000	0.411202	0.399352	0.981679	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0210
HHA CCN: 14-7419

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

Worksheet H-2 Part II
Date/Time Prepared: 12/17/2018 2:39 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		15.00	16.00	19.00			
1.00	Administrative and General	0	794,309	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	794,309	0			20.00
21.00	Total cost to be allocated	0	6,309	0			21.00
22.00	Unit cost multiplier	0.000000	0.007943	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 12/17/2018 2:39 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	517,501		517,501	2,024	255.68	1.00
2.00	Physical Therapy	3.00	212,282	0	212,282	1,267	167.55	2.00
3.00	Occupational Therapy	4.00	5,113	0	5,113	40	127.83	3.00
4.00	Speech Pathology	5.00	7,421	0	7,421	39	190.28	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		742,317	0	742,317	3,370		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	856			8.00
9.00	Physical Therapy		99914	0	641			9.00
10.00	Occupational Therapy		99914	0	13			10.00
11.00	Speech Pathology		99914	0	11			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	0			13.00
14.00	Total (sum of lines 8-13)			0	1,521			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	9,034	9,034	21,505	0.420088	15.00
16.00	Cost of Drugs	9.00	0	15	15	54	0.277778	16.00

	Cost Center Description	Program Visits Part A	Part B Not Subject to Deductibles & Coinsurance	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	856		0	218,862		1.00
2.00	Physical Therapy	0	641		0	107,400		2.00
3.00	Occupational Therapy	0	13		0	1,662		3.00
4.00	Speech Pathology	0	11		0	2,093		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,521		0	330,017		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: 14-0210 HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 12/17/2018 2:39 pm

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	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	22,358	0	0	9,392	0	15.00
16.00	Cost of Drugs		54	0		15	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	218,862	1.00
2.00	Physical Therapy	107,400	2.00
3.00	Occupational Therapy	1,662	3.00
4.00	Speech Pathology	2,093	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	330,017	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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 12/17/2018 2:39 pm

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	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	0.375137	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.311279	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.728350	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.404079	22,358	9,034	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.270798	54	15	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 12/17/2018 2:39 pm

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		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	15	0	1.00
2.00	Total charges	0	54	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	54	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	39	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	15	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	300,109	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	2,711	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	19,700	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,271	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	736	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	325,542	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	325,542	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	325,542	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	325,542	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	325,542	31.00
31.01	Sequestration adjustment (see instructions)	0	6,511	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	319,070	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	-39	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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-5 | Date/Time Prepared: 12/17/2018 2:39 pm

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		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		319,070	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		319,070	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		39	6.02
7.00	Total Medicare program liability (see instructions)		0		319,031	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0210	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 12/17/2018 2:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	470,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	15.08	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)	470,815	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: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	450,935	0	450,935	0	450,935	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	397,922	0	397,922	0	397,922	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	224,347	0	224,347	0	224,347	5.00
6.00	Clinical Psychologist	181,989	0	181,989	0	181,989	6.00
7.00	Clinical Social Worker	66,376	0	66,376	0	66,376	7.00
8.00	Laboratory Technician	45,658	0	45,658	-45,658	0	8.00
9.00	Other Facility Health Care Staff Costs	57,552	0	57,552	-57,552	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,424,779	0	1,424,779	-103,210	1,321,569	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	1,380	1,380	50,087	51,467	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,380	1,380	50,087	51,467	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,424,779	1,380	1,426,159	-53,123	1,373,036	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	103,744	103,744	-50,087	53,657	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	103,744	103,744	-50,087	53,657	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	74,274	74,274	148,784	223,058	29.00
30.00	Administrative Costs	268,700	141,698	410,398	-18,099	392,299	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	268,700	215,972	484,672	130,685	615,357	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,693,479	321,096	2,014,575	27,475	2,042,050	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	450,935		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	397,922		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	224,347		5.00
6.00	Clinical Psychologist	0	181,989		6.00
7.00	Clinical Social Worker	0	66,376		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,321,569		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	51,467		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	51,467		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,373,036		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	53,657		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	53,657		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	223,058		29.00
30.00	Administrative Costs	-14,043	378,256		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-14,043	601,314		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-14,043	2,028,007		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	29,868	0	29,868	0	29,868	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	101,252	0	101,252	0	101,252	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	42,054	0	42,054	0	42,054	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	173,174	0	173,174	0	173,174	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	263	263	5,649	5,912	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	263	263	5,649	5,912	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	173,174	263	173,437	5,649	179,086	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	9,500	9,500	-5,649	3,851	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	9,500	9,500	-5,649	3,851	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	27,506	27,506	0	27,506	29.00
30.00	Administrative Costs	23,058	23,521	46,579	-6,958	39,621	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,058	51,027	74,085	-6,958	67,127	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	196,232	60,790	257,022	-6,958	250,064	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	29,868		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	101,252		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	42,054		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	173,174		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	5,912		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,912		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	179,086		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	3,851		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	3,851		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	27,506		29.00
30.00	Administrative Costs	0	39,621		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,127		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	250,064		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	24,975	0	24,975	0	24,975	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	107,049	0	107,049	0	107,049	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	42,443	0	42,443	0	42,443	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	174,467	0	174,467	0	174,467	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	292	292	2,909	3,201	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	292	292	2,909	3,201	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	174,467	292	174,759	2,909	177,668	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	20,696	20,696	-2,909	17,787	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	20,696	20,696	-2,909	17,787	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	25,514	25,514	3,893	29,407	29.00
30.00	Administrative Costs	34,179	35,019	69,198	-5,347	63,851	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	34,179	60,533	94,712	-1,454	93,258	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	208,646	81,521	290,167	-1,454	288,713	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	24,975		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	107,049		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	42,443		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	174,467		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	3,201		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,201		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	177,668		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	17,787		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	17,787		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	29,407		29.00
30.00	Administrative Costs	0	63,851		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,258		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	288,713		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8589 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	408,904	0	408,904	-72,819	336,085	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	238,729	0	238,729	-42,514	196,215	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	132,785	0	132,785	-23,647	109,138	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	50,060	0	50,060	-8,915	41,145	8.00
9.00	Other Facility Health Care Staff Costs	59,785	0	59,785	-10,647	49,138	9.00
10.00	Subtotal (sum of lines 1 through 9)	890,263	0	890,263	-158,542	731,721	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	1,209	1,209	-215	994	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,209	1,209	-215	994	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	890,263	1,209	891,472	-158,757	732,715	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	120,649	120,649	-21,485	99,164	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	120,649	120,649	-21,485	99,164	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	152,218	152,218	-27,107	125,111	29.00
30.00	Administrative Costs	179,443	208,364	387,807	-69,345	318,462	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	179,443	360,582	540,025	-96,452	443,573	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,069,706	482,440	1,552,146	-276,694	1,275,452	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-0210 | Component CCN: 14-8589 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	-306,958	29,127		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-179,210	17,005		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	-99,680	9,458		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	-37,579	3,566		8.00
9.00	Other Facility Health Care Staff Costs	-44,880	4,258		9.00
10.00	Subtotal (sum of lines 1 through 9)	-668,307	63,414		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	-908	86		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-908	86		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-669,215	63,500		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	-90,569	8,595		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)	-90,569	8,595		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-114,268	10,843		29.00
30.00	Administrative Costs	-291,121	27,341		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-405,389	38,184		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,165,173	110,279		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	277,158	0	277,158	-49,357	227,801	1.00
2.00	Physician Assistant	169,964	0	169,964	-30,268	139,696	2.00
3.00	Nurse Practitioner	19,027	0	19,027	-3,388	15,639	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	122,876	0	122,876	-21,882	100,994	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	48,244	0	48,244	-8,591	39,653	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	637,269	0	637,269	-113,486	523,783	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	1,478	1,478	-263	1,215	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,478	1,478	-263	1,215	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	637,269	1,478	638,747	-113,749	524,998	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	70,330	70,330	-12,525	57,805	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	70,330	70,330	-12,525	57,805	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	138,086	138,086	-24,590	113,496	29.00
30.00	Administrative Costs	115,676	174,704	290,380	-52,293	238,087	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	115,676	312,790	428,466	-76,883	351,583	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	752,945	384,598	1,137,543	-203,157	934,386	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 12/17/2018 2:39 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	-208,058	19,743		1.00
2.00	Physician Assistant	-127,589	12,107		2.00
3.00	Nurse Practitioner	-14,283	1,356		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	-92,241	8,753		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	-36,216	3,437		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-478,387	45,396		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	-1,110	105		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-1,110	105		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-479,497	45,501		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	-52,796	5,009		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)	-52,796	5,009		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-103,659	9,837		29.00
30.00	Administrative Costs	-217,984	20,103		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-321,643	29,940		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-853,936	80,450		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 12/17/2018 2:39 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.71	5,518	4,200	7,182		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.17	9,615	2,100	6,657		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.88	15,133		13,839	15,133	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	1.67	1,524			1,524	6.00
7.00	Clinical Social Worker	0.95	957			957	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.50	17,614			17,614	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)					1,373,036	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					53,657	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,426,693	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.962391	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					601,314	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,300,695	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,902,009	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,902,009	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,830,476	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,203,512	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 12/17/2018 2:39 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	0.02	100	4,200	84		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	2,007	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.92	2,107		1,974	2,107	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)	0.92	2,107			2,107	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)					179,086	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,851	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					182,937	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.978949	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					67,127	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					170,451	15.00
16.00	Total overhead (sum of lines 14 and 15)					237,578	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					237,578	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					232,577	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					411,663	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 12/17/2018 2:39 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.04	2,515	2,100	2,184		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.04	2,515		2,184	2,515	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)	1.04	2,515			2,515	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)					177,668	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					17,787	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					195,455	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.908997	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					93,258	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					174,430	15.00
16.00	Total overhead (sum of lines 14 and 15)					267,688	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					267,688	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					243,328	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					420,996	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8589 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 12/17/2018 2:39 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	0.07	272	4,200	294		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.11	422	2,100	231		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.18	694		525	694	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)	0.18	694			694	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)					63,500	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					8,595	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					72,095	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.880782	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					38,184	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					124,459	15.00
16.00	Total overhead (sum of lines 14 and 15)					162,643	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					162,643	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					143,253	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					206,753	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 12/17/2018 2:39 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	0.06	335	4,200	252		1.00
2.00	Physician Assistant	0.07	179	2,100	147		2.00
3.00	Nurse Practitioner	0.01	97	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.14	611		420	611	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)	0.14	611			611	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)					45,501	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5,009	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					50,510	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.900832	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					29,940	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					77,841	15.00
16.00	Total overhead (sum of lines 14 and 15)					107,781	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					107,781	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					97,093	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					142,594	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 12/17/2018 2:39 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,203,512	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			127,727	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,075,785	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,614	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)			17,614	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			174.62	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)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	174.62	174.62		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,309		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	752,438		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	282		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	49,243		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	49,243		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	801,681		16.00
16.01	Total program charges (see instructions)(from contractor's records)		784,780		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		30,772		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,435		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.)		562,007		16.04
16.05	Total program cost (see instructions)	0	593,442		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		67,737		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		137,254		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		593,442		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		42,677		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		636,119		22.00
23.00	Allowable bad debts (see instructions)		37,702		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		24,506		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)		660,625		26.00
26.01	Sequestration adjustment (see instructions)		13,213		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		618,627		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)		28,785		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: 14-0210 Component CCN: 14-8518	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 12/17/2018 2:39 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)		411,663	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,454	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		397,209	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,107	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)		2,107	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		188.52	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	188.52	188.52	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	376	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	70,884	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	70,884	16.00
16.01	Total program charges (see instructions)(from contractor's records)		57,854	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,246	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,527	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.)		51,858	16.04
16.05	Total program cost (see instructions)	0	53,385	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,534	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,415	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		53,385	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,935	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		56,320	22.00
23.00	Allowable bad debts (see instructions)		3,474	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,258	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)		58,578	26.00
26.01	Sequestration adjustment (see instructions)		1,172	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		49,102	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)		8,304	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 12/17/2018 2:39 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)			420,996	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,621	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			413,375	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,515	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)			2,515	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			164.36	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)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	164.36	164.36		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	405		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	66,566		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	66,566		16.00
16.01	Total program charges (see instructions)(from contractor's records)		59,724		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		187		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		208		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.)		46,626		16.04
16.05	Total program cost (see instructions)	0	46,834		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,075		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,292		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,834		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,126		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		50,960		22.00
23.00	Allowable bad debts (see instructions)		765		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		497		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)		51,457		26.00
26.01	Sequestration adjustment (see instructions)		1,029		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		35,584		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)		14,844		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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 12/17/2018 2:39 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)		206,753	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		206,753	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		694	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)		694	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		297.91	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	297.91	297.91	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	146	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	43,495	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	43,495	16.00
16.01	Total program charges (see instructions)(from contractor's records)		25,043	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		95	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		165	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.)		33,801	16.04
16.05	Total program cost (see instructions)	0	33,966	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,079	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,774	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		33,966	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		33,966	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)		33,966	26.00
26.01	Sequestration adjustment (see instructions)		679	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		6,714	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)		26,573	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: 14-0210 Component CCN: 14-8590	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 12/17/2018 2:39 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)			142,594	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			142,594	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			611	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)			611	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			233.38	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)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	233.38	233.38		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	158		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	36,874		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	36,874		16.00
16.01	Total program charges (see instructions)(from contractor's records)		28,244		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		380		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		496		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.)		28,066		16.04
16.05	Total program cost (see instructions)	0	28,562		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,295		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,314		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		28,562		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		28,562		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)		28,562		26.00
26.01	Sequestration adjustment (see instructions)		571		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		7,166		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)		20,825		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: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 12/17/2018 2:39 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,321,569	1,321,569	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001058	0.002467	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,398	3,260	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	36,844	13,243	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	38,242	16,503	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,373,036	1,373,036	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,830,476	1,830,476	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027852	0.012019	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	50,982	22,000	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	89,224	38,503	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	347	809	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	257.13	47.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	121	243	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	31,113	11,564	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)		127,727	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)		42,677	16.00

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

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 12/17/2018 2:39 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)	173,174	173,174	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000813	0.002878	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	141	498	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,505	2,144	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,646	2,642	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	179,086	179,086	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	232,577	232,577	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020359	0.014753	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,735	3,431	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,381	6,073	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	37	131	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	226.51	46.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,359	1,576	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)		14,454	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)		2,935	16.00

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

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 12/17/2018 2:39 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)	174,467	174,467	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000176	0.001581	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	31	276	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,553	1,356	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,584	1,632	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	177,668	177,668	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	243,328	243,328	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008916	0.009186	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,170	2,235	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,754	3,867	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	81	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	417.11	47.74	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,503	1,623	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)		7,621	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,126	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 12/17/2018 2:39 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		618,627	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)		618,627	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		28,785	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		647,412	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: 14-0210 Component CCN: 14-8518	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 12/17/2018 2:39 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		49,102	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)		49,102	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		8,304	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		57,406	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 12/17/2018 2:39 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		35,584	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)		35,584	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		14,844	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		50,428	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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 12/17/2018 2:39 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		6,714	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)		6,714	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		26,573	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		33,287	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: 14-0210 Component CCN: 14-8590	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 12/17/2018 2:39 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		7,166	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)		7,166	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		20,825	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		27,991	7.00

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