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: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/25/2019 8:32 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
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 BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	406,761	-489,502	0	0	1.00
2.00	Subprovider - IPF	0	20,408	50		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	126,386	-239		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		90,073		0	10.00
200.00	Total	0	553,555	-399,618	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 8:32 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 640 WEST WASHINGTON	PO Box:			1.00
2.00	City: PITTSFIELD	State: IL	Zip Code: 62363	County: PIKE	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	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF	BCC DBA ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BCC DBA ILLINI COMM HOSP-RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2017	09/30/2018	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.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	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.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 8:32 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 8:32 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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 8:32 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		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 8:32 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.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 8:32 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	82,442	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 8:32 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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	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)	10/01/2017	09/30/2018	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2019 8:32 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2018	Y	12/31/2018	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 8:32 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				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.	CONNIE		ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159		CZIEGLER@BLESSINGHOSPITAL.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 8:32 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.	REIMBURSEMENT COORDINATOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part IX Date/Time Prepared: 2/25/2019 8:32 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2019 8:32 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	25	9,125	17,736.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	17,736.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	17,736.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				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

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	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)	579	42	739			1.00
2.00	HMO and other (see instructions)	54	19				2.00
3.00	HMO IPF Subprovider	212	148				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	222	0	222			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	66			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	801	42	1,027			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)	801	42	1,027	0.00	148.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	741	152	1,434	0.00	17.76	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,416	0	8,931	0.00	11.72	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	177.99	27.00
28.00	Observation Bed Days		17	137			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			3			30.00
31.00	Employee discount days - IRF			3			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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2019 8:32 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	196	20	271	1.00
2.00	HMO and other (see instructions)			17	10		2.00
3.00	HMO IPF Subprovider				23		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	196	20	271	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	105	23	204	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/25/2019 8:32 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			640 WEST WASHINGTON		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PITTSFIELD		IL	62363	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			07:00	17:30	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				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		PIKE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:00	17:30	07:00	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1315
Component CCN: 14-3482

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8
Date/Time Prepared:
2/25/2019 8:32 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:30	07:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 2/25/2019 8:32 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)	0.390515	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,842,328	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	1,959,336	5.00
6.00	Medicaid charges	13,709,582	6.00
7.00	Medicaid cost (line 1 times line 6)	5,353,797	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)	552,133	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	552,133	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)	1,227,272	229,969	1,457,241	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	479,268	229,969	709,237	21.00
22.00	Payments received from patients for amounts previously written off as charity care	13,359	28,328	41,687	22.00
23.00	Cost of charity care (line 21 minus line 22)	465,909	201,641	667,550	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)	1,654,693	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	268,390	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	412,908	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,241,785	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	629,454	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,297,004	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,849,137	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 8:32 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		697,146	697,146	50,418	747,564	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		391,954	391,954	3,232	395,186	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,989,328	3,989,328	0	3,989,328	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,557,253	2,101,743	3,658,996	-19,588	3,639,408	5.00
6.00	00600	MAINTENANCE & REPAIRS	452,193	456,389	908,582	0	908,582	6.00
7.00	00700	OPERATION OF PLANT	0	360,621	360,621	37,807	398,428	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,074	59,074	0	59,074	8.00
9.00	00900	HOUSEKEEPING	305,776	135,435	441,211	0	441,211	9.00
10.00	01000	DIETARY	183,396	132,060	315,456	0	315,456	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	336,736	14,937	351,673	-68,514	283,159	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,725	41,324	72,049	0	72,049	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	134,008	134,008	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	41,695	41,695	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,030,010	124,263	1,154,273	-69,869	1,084,404	30.00
40.00	04000	SUBPROVIDER - IPF	831,445	118,777	950,222	-3,932	946,290	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,061	152,017	566,078	-26,708	539,370	50.00
53.00	05300	ANESTHESIOLOGY	41,695	5,947	47,642	-47,642	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	812,749	459,277	1,272,026	-2,389	1,269,637	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	55,428	30,547	85,975	-24,359	61,616	54.01
60.00	06000	LABORATORY	507,952	857,359	1,365,311	-36,294	1,329,017	60.00
65.00	06500	RESPIRATORY THERAPY	147,129	52,497	199,626	-18,446	181,180	65.00
65.01	03610	SLEEP LAB	304	45,198	45,502	0	45,502	65.01
66.00	06600	PHYSICAL THERAPY	72,138	47,375	119,513	0	119,513	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,383	93,909	138,292	146,377	284,669	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	414,180	3,330,560	3,744,740	-1,268	3,743,472	73.00
73.01	03480	ONCOLOGY	166,666	268,126	434,792	0	434,792	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	685,571	636,071	1,321,642	-1,860	1,319,782	88.00
91.00	09100	EMERGENCY	775,511	2,185,700	2,961,211	-23,331	2,937,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		100,367	100,367	0	100,367	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,865,301	16,888,001	25,753,302	69,337	25,822,639	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53,439	36,441	89,880	0	89,880	192.00
192.01	19201	XPRESS CARE	357,810	47,129	404,939	0	404,939	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	149,904	56,415	206,319	-69,337	136,982	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	9,426,454	17,027,986	26,454,440	0	26,454,440	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 8:32 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	200,876	948,440		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	85,873	481,059		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-530,219	3,459,109		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,023,789	5,663,197		5.00
6.00	00600	MAINTENANCE & REPAIRS	-10,493	898,089		6.00
7.00	00700	OPERATION OF PLANT	-4,524	393,904		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	59,264		8.00
9.00	00900	HOUSEKEEPING	0	441,211		9.00
10.00	01000	DIETARY	-48,651	266,805		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	283,159		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,438	313,487		16.00
17.00	01700	SOCIAL SERVICE	0	134,008		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	41,695		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	16,618	1,101,022		30.00
40.00	04000	SUBPROVIDER - IPF	-29,743	916,547		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,984	537,386		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,515	1,249,122		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	61,616		54.01
60.00	06000	LABORATORY	-257,952	1,071,065		60.00
65.00	06500	RESPIRATORY THERAPY	0	181,180		65.00
65.01	03610	SLEEP LAB	-11,396	34,106		65.01
66.00	06600	PHYSICAL THERAPY	0	119,513		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,448	334,117		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,658	3,809,130		73.00
73.01	03480	ONCOLOGY	-259,500	175,292		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-48,776	1,271,006		88.00
91.00	09100	EMERGENCY	-1,588,675	1,349,205		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-100,367	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-228,905	25,593,734		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-182	89,698		192.00
192.01	19201	XPRESS CARE	0	404,939		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	RENAL	0	0		193.01
193.02	19302	LEASED SPACE	0	0		193.02
193.03	19303	UNUSED SPACE	0	0		193.03
193.04	19304	WELLNESS	0	136,982		193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-229,087	26,225,353		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 2/25/2019 8:32 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
40.00	SUBPROVIDER - IPF	04000		40.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.01
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03610	SLEEP LAB	65.01
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	03480	ONCOLOGY	73.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	XPRESS CARE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.01	RENAL	19301		193.01
193.02	LEASED SPACE	19302		193.02
193.03	UNUSED SPACE	19303		193.03
193.04	WELLNESS	19304		193.04
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 8:32 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,000		1.00
	TOTALS		0	10,000		
	B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	37,807		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	37,807		
	C - RELCASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	146,377		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	146,377		
	E - RECLASS NURSING MANAGER SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	68,514	0		1.00
	TOTALS		68,514	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	4,019		1.00
	TOTALS		0	4,019		
	H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	41,695	0		1.00
	TOTALS		41,695	0		
	J - RECLASS SOCIAL WORKERS SALARY					
1.00	SOCIAL SERVICE	17.00	134,008	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		134,008	0		
	K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	43,650		1.00
	TOTALS		0	43,650		
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	18,663	7,024		1.00
	TOTALS		18,663	7,024		
500.00	Grand Total: Increases		262,880	248,877		500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 8:32 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	TOTALS		0	10,000			
	B - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,462	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	180	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	165	0		3.00
	TOTALS		0	37,807			
	C - RELCASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	6,085	0		1.00
2.00	SUBPROVIDER - IPF	40.00	0	35	0		2.00
3.00	OPERATING ROOM	50.00	0	30,727	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	1,928	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,389	0		5.00
6.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	24,359	0		6.00
7.00	LABORATORY	60.00	0	36,294	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	18,446	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,088	0		9.00
10.00	EMERGENCY	91.00	0	23,331	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,695	0		11.00
	TOTALS		0	146,377			
	E - RECLASS NURSING MANAGER SALARY						
1.00	NURSING ADMINISTRATION	13.00	68,514	0	0		1.00
	TOTALS		68,514	0			
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	4,019	0		1.00
	TOTALS		0	4,019			
	H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	41,695	0	0		1.00
	TOTALS		41,695	0			
	J - RECLASS SOCIAL WORKERS SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	66,327	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	63,784	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	3,897	0	0		3.00
	TOTALS		134,008	0			
	K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.04	0	43,650	10		1.00
	TOTALS		0	43,650			
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.04	18,663	7,024	0		1.00
	TOTALS		18,663	7,024			
500.00	Grand Total: Decreases		262,880	248,877			500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 2/25/2019 8:32 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS PROPERTY INSURANCE								
1.00	OTHER CAP REL COSTS	3.00	0	10,000	ADMINISTRATIVE & GENERAL	5.00	0	10,000	1.00
	TOTALS		0	10,000	TOTALS		0	10,000	
	B - RECLASS UTILITIES								
1.00	OPERATION OF PLANT	7.00	0	37,807	ADMINISTRATIVE & GENERAL	5.00	0	37,462	1.00
2.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	180	2.00
3.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	165	3.00
	TOTALS		0	37,807	TOTALS		0	37,807	
	C - RELCASS MEDICAL SUPPLIES EXPENSE								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	146,377	ADULTS & PEDIATRICS	30.00	0	6,085	1.00
2.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	35	2.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	30,727	3.00
4.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	1,928	4.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	2,389	5.00
6.00		0.00	0	0	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	24,359	6.00
7.00		0.00	0	0	LABORATORY	60.00	0	36,294	7.00
8.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	18,446	8.00
9.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	1,088	9.00
10.00		0.00	0	0	EMERGENCY	91.00	0	23,331	10.00
11.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	1,695	11.00
	TOTALS		0	146,377	TOTALS		0	146,377	
	E - RECLASS NURSING MANAGER SALARY								
1.00	ADMINISTRATIVE & GENERAL	5.00	68,514	0	NURSING ADMINISTRATION	13.00	68,514	0	1.00
	TOTALS		68,514	0	TOTALS		68,514	0	
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE								
1.00	OPERATING ROOM	50.00	0	4,019	ANESTHESIOLOGY	53.00	0	4,019	1.00
	TOTALS		0	4,019	TOTALS		0	4,019	
	H - RECLASS CRNA COSTS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	41,695	0	ANESTHESIOLOGY	53.00	41,695	0	1.00
	TOTALS		41,695	0	TOTALS		41,695	0	
	J - RECLASS SOCIAL WORKERS SALARY								
1.00	SOCIAL SERVICE	17.00	134,008	0	ADMINISTRATIVE & GENERAL	5.00	66,327	0	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	63,784	0	2.00
3.00		0.00	0	0	SUBPROVIDER - IPF	40.00	3,897	0	3.00
	TOTALS		134,008	0	TOTALS		134,008	0	
	K - RECLASS BUILDING RENT								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	43,650	WELLNESS	193.04	0	43,650	1.00
	TOTALS		0	43,650	TOTALS		0	43,650	
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE								
1.00	ADMINISTRATIVE & GENERAL	5.00	18,663	7,024	WELLNESS	193.04	18,663	7,024	1.00
	TOTALS		18,663	7,024	TOTALS		18,663	7,024	
500.00	Grand Total: Increases		262,880	248,877	Grand Total: Decreases		262,880	248,877	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2019 8:32 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	279,691	0	0	0	0	1.00
2.00	Land Improvements	550,487	0	0	0	17,000	2.00
3.00	Buildings and Fixtures	12,805,883	0	0	0	0	3.00
4.00	Building Improvements	2,726,814	374,724	0	374,724	17,860	4.00
5.00	Fixed Equipment	62,799	10,465	0	10,465	0	5.00
6.00	Movable Equipment	7,470,223	242,631	0	242,631	124,365	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,895,897	627,820	0	627,820	159,225	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,895,897	627,820	0	627,820	159,225	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	279,691	0	1.00
2.00	Land Improvements	533,487	0	2.00
3.00	Buildings and Fixtures	12,805,883	0	3.00
4.00	Building Improvements	3,083,678	0	4.00
5.00	Fixed Equipment	73,264	0	5.00
6.00	Movable Equipment	7,588,489	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,364,492	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,364,492	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2019 8:32 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	697,146	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	391,954	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,089,100	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	697,146		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	391,954		2.00
3.00	Total (sum of lines 1-2)	0	1,089,100		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2019 8:32 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	15,889,560	0	15,889,560	0.676784	6,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,588,489	0	7,588,489	0.323216	3,232	2.00
3.00	Total (sum of lines 1-2)	23,478,049	0	23,478,049	1.000000	10,000	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	6,768	898,022	43,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,232	477,827	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,375,849	43,650	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	0	6,768	0	0	948,440	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,232	0	0	481,059	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	1,429,499	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 8:32 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-100,367	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,880,030			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	1,756,055			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	-65	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-95,060	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 8:32 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	MISCELLANEOUS SUPPLIES REVENUE	B	-11,774	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	CABLE TELEVISION	A	-4,524	OPERATION OF PLANT	7.00	0	33.02
33.03	MISCELLANEOUS EXPENSE	A	-4,000	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PUBLIC RELATIONS SALARIES	A	-2,869	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-1,214	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	PUBLIC RELATIONS EXPENSES	A	-96,766	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ASSET RELIFING	A	200,876	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	ASSET RELIFING	A	73,944	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	COFFEE SHOP RECEIPTS	B	-47,920	DIETARY	10.00	0	33.09
33.10	MEALS ON WHEELS	B	-1,566	DIETARY	10.00	0	33.10
33.11	LOBBYING EXPENSE	A	-10,929	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MISCELLANEOUS	B	-940	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	MISCELLANEOUS	B	-640	RURAL HEALTH CLINIC	88.00	0	33.13
33.14	ACCOUNTING FEES	B	-1,298	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-229,087				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2019 8:32 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,021,223	990,654	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	241,503	0	2.00
3.00	10.00	DIETARY	DIETICIAN	5,006	4,171	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	82,717	82,527	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	529,005	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	312,363	357,352	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	6,663	11,447	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	7,204	21,344	4.04
4.05	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	128,747	63,089	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	0	7,195	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	230,903	13,842	4.07
4.08	60.00	LABORATORY	LABORATORY TESTS	105,700	363,652	4.08
4.09	65.01	SLEEP LAB	SLEEP STUDIES	31,509	42,905	4.09
4.10	30.00	ADULTS & PEDIATRICS	BIO-MED	443	904	4.10
4.11	50.00	OPERATING ROOM	BIO-MED	600	1,224	4.11
4.12	91.00	EMERGENCY	BIO-MED	410	835	4.12
4.13	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	175	357	4.13
4.14	50.00	OPERATING ROOM	BIO-MED	1,310	2,670	4.14
4.15	88.00	RURAL HEALTH CLINIC	BIO-MED	50	102	4.15
4.16	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	6,138	12,513	4.16
4.17	6.00	MAINTENANCE & REPAIRS	BIO-MED	10,101	20,594	4.17
4.18	30.00	ADULTS & PEDIATRICS	TELEMETRY SERVICES	28,089	11,010	4.18
4.19	88.00	RURAL HEALTH CLINIC	CARE COORDINATION	61,271	64,366	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	61,222	0	4.20
4.21	91.00	EMERGENCY	ER PHYSICIAN	89,015	86,478	4.21
4.22	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	11,929	0	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,444,291	2,688,236	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office Name	Related Organization(s) and/or Home Office Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	BLESSING CORP S	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2019 8:32 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,030,569	0		1.00
2.00	241,503	0		2.00
3.00	835	0		3.00
4.00	190	0		4.00
4.01	-529,005	0		4.01
4.02	-44,989	0		4.02
4.03	-4,784	0		4.03
4.04	-14,140	0		4.04
4.05	65,658	0		4.05
4.06	-7,195	0		4.06
4.07	217,061	0		4.07
4.08	-257,952	0		4.08
4.09	-11,396	0		4.09
4.10	-461	0		4.10
4.11	-624	0		4.11
4.12	-425	0		4.12
4.13	-182	0		4.13
4.14	-1,360	0		4.14
4.15	-52	0		4.15
4.16	-6,375	0		4.16
4.17	-10,493	0		4.17
4.18	17,079	0		4.18
4.19	-3,095	0		4.19
4.20	61,222	0		4.20
4.21	2,537	0		4.21
4.22	11,929	9		4.22
5.00	1,756,055			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	LAUNDRY		8.00
9.00	BIO-MED		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2019 8:32 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	60.00	LABORATORY	14,727	0	14,727	0	0	1.00
2.00	73.01	ONCOLOGY	259,500	259,500	0	0	0	2.00
3.00	91.00	EMERGENCY	2,119,275	1,590,787	528,488	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	2,058	0	2,058	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	29,743	29,743	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,425,303	1,880,030	545,273		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	259,500		2.00
3.00	91.00	EMERGENCY	0	0	0	1,590,787		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0		4.00
5.00	40.00	SUBPROVIDER - IPF	0	0	0	29,743		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,880,030		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/25/2019 8:32 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					195	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	313.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.78	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.89	40.89	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					25,638	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					25,638	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					25,638	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					81.78	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					63,788	22.00
23.00	Total salary equivalency (see instructions)					63,788	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					7,974	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,974	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					673	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,647	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,647	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/25/2019 8:32 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.78	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	63,788	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,647	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	72,435	63.00
64.00	Total cost of outside supplier services (from your records)	29,783	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,974	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	673	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,647	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	673	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	673	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 8:32 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	948,440	948,440				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	481,059		481,059			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,459,109	0	0	3,459,109		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,663,197	247,983	133,927	578,221	6,623,328	5.00
6.00	00600	MAINTENANCE & REPAIRS	898,089	165,696	89,487	165,986	1,319,258	6.00
7.00	00700	OPERATION OF PLANT	393,904	0	0	0	393,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,264	7,309	3,947	0	70,520	8.00
9.00	00900	HOUSEKEEPING	441,211	15,715	8,487	112,241	577,654	9.00
10.00	01000	DIETARY	266,805	14,969	8,084	67,319	357,177	10.00
11.00	01100	CAFETERIA	0	4,244	2,292	0	6,536	11.00
13.00	01300	NURSING ADMINISTRATION	283,159	1,426	770	98,456	383,811	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313,487	10,283	5,553	11,278	340,601	16.00
17.00	01700	SOCIAL SERVICE	134,008	1,024	553	49,190	184,775	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	41,695	0	0	15,305	57,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,101,022	57,215	30,900	354,672	1,543,809	30.00
40.00	04000	SUBPROVIDER - IPF	916,547	45,670	24,665	303,767	1,290,649	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,386	44,064	23,798	151,989	757,237	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,249,122	27,899	15,067	298,335	1,590,423	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	61,616	3,605	1,947	20,346	87,514	54.01
60.00	06000	LABORATORY	1,071,065	16,346	8,828	186,453	1,282,692	60.00
65.00	06500	RESPIRATORY THERAPY	181,180	9,513	5,137	54,006	249,836	65.00
65.01	03610	SLEEP LAB	34,106	901	487	112	35,606	65.01
66.00	06600	PHYSICAL THERAPY	119,513	0	0	26,480	145,993	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	334,117	6,997	3,779	16,292	361,185	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,809,130	11,102	5,996	152,033	3,978,261	73.00
73.01	03480	ONCOLOGY	175,292	25,342	13,687	61,178	275,499	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,271,006	47,604	25,709	251,652	1,595,971	88.00
91.00	09100	EMERGENCY	1,349,205	41,295	22,302	284,666	1,697,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,593,734	806,202	435,402	3,259,977	25,206,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	89,698	25,482	13,762	19,616	148,558	192.00
192.01	19201	XPRESS CARE	404,939	0	8,571	131,341	544,851	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	14,150	0	0	14,150	193.01
193.02	19302	LEASED SPACE	0	55,379	0	0	55,379	193.02
193.03	19303	UNUSED SPACE	0	4,039	0	0	4,039	193.03
193.04	19304	WELLNESS	136,982	43,188	23,324	48,175	251,669	193.04
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)	26,225,353	948,440	481,059	3,459,109	26,225,353	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,623,328					5.00
6.00	00600	MAINTENANCE & REPAIRS	445,764	1,765,022				6.00
7.00	00700	OPERATION OF PLANT	133,096	0	527,000			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,828	23,600	7,202	125,150		8.00
9.00	00900	HOUSEKEEPING	195,184	50,746	15,487	0	839,071	9.00
10.00	01000	DIETARY	120,687	48,338	14,752	0	23,990	10.00
11.00	01100	CAFETERIA	2,208	13,705	4,183	0	6,802	11.00
13.00	01300	NURSING ADMINISTRATION	129,686	4,604	1,405	0	2,285	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,086	33,204	10,134	0	16,479	16.00
17.00	01700	SOCIAL SERVICE	62,434	3,307	1,009	0	1,641	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19,260	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	521,638	184,755	56,381	52,226	91,693	30.00
40.00	04000	SUBPROVIDER - IPF	436,097	147,475	45,007	72,924	73,191	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	255,863	142,290	43,425	0	70,617	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,388	90,089	27,494	0	44,710	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	29,570	11,641	3,553	0	5,778	54.01
60.00	06000	LABORATORY	433,409	52,783	16,109	0	26,196	60.00
65.00	06500	RESPIRATORY THERAPY	84,417	30,717	9,375	0	15,245	65.00
65.01	03610	SLEEP LAB	12,031	2,910	888	0	1,444	65.01
66.00	06600	PHYSICAL THERAPY	49,330	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,041	22,595	6,896	0	11,214	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,344,213	35,850	10,941	0	17,792	73.00
73.01	03480	ONCOLOGY	93,088	81,834	24,975	0	40,614	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	539,263	153,719	46,913	0	76,290	88.00
91.00	09100	EMERGENCY	573,557	133,347	40,696	0	66,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,279,138	1,267,509	386,825	125,150	592,160	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,196	82,284	25,112	0	40,837	192.00
192.01	19201	XPRESS CARE	184,100	51,249	0	0	25,434	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	4,781	45,693	13,945	0	22,677	193.01
193.02	19302	LEASED SPACE	18,712	178,828	54,576	0	88,751	193.02
193.03	19303	UNUSED SPACE	1,365	0	3,981	0	0	193.03
193.04	19304	WELLNESS	85,036	139,459	42,561	0	69,212	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,623,328	1,765,022	527,000	125,150	839,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	564,944					10.00
11.00	01100	CAFETERIA	0	33,434				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,397	523,188			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	160	0	515,664		16.00
17.00	01700	SOCIAL SERVICE	0	698	0	0	253,864	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	217	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	235,757	5,036	125,079	23,830	105,940	30.00
40.00	04000	SUBPROVIDER - IPF	329,187	4,311	89,758	27,405	147,924	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,157	66,128	18,460	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	618	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,234	912	157,133	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	289	4,296	7,877	0	54.01
60.00	06000	LABORATORY	0	2,646	0	85,279	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	766	14,141	17,284	0	65.00
65.01	03610	SLEEP LAB	0	2	0	3,858	0	65.01
66.00	06600	PHYSICAL THERAPY	0	376	0	3,266	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	231	0	12,472	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,157	0	92,307	0	73.00
73.01	03480	ONCOLOGY	0	868	20,707	6,987	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,571	50,789	0	0	88.00
91.00	09100	EMERGENCY	0	4,040	138,965	58,888	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	564,944	33,156	510,775	515,664	253,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	278	9,794	0	0	192.00
192.01	19201	XPRESS CARE	0	0	2,619	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	564,944	33,434	523,188	515,664	253,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	76,477					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,946,144	0	2,946,144		30.00
40.00	04000	SUBPROVIDER - IPF	0	2,663,928	0	2,663,928		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,356,177	0	1,356,177		50.00
53.00	05300	ANESTHESIOLOGY	76,477	77,095	0	77,095		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,452,383	0	2,452,383		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	150,518	0	150,518		54.01
60.00	06000	LABORATORY	0	1,899,114	0	1,899,114		60.00
65.00	06500	RESPIRATORY THERAPY	0	421,781	0	421,781		65.00
65.01	03610	SLEEP LAB	0	56,739	0	56,739		65.01
66.00	06600	PHYSICAL THERAPY	0	198,965	0	198,965		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	536,634	0	536,634		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,481,521	0	5,481,521		73.00
73.01	03480	ONCOLOGY	0	544,572	0	544,572		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,466,516	0	2,466,516		88.00
91.00	09100	EMERGENCY	0	2,713,140	0	2,713,140		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,477	23,965,227	0	23,965,227		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	357,059	0	357,059		192.00
192.01	19201	XPRESS CARE	0	808,253	0	808,253		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	RENAL	0	101,246	0	101,246		193.01
193.02	19302	LEASED SPACE	0	396,246	0	396,246		193.02
193.03	19303	UNUSED SPACE	0	9,385	0	9,385		193.03
193.04	19304	WELLNESS	0	587,937	0	587,937		193.04
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)	76,477	26,225,353	0	26,225,353		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 2/25/2019 8:32 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	8	PATIENT DAYS	10.00
11.00	CAFETERIA	11	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	13	NURSING SALARIES	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TOTAL CHARGES	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 8:32 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	247,983	133,927	381,910	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	165,696	89,487	255,183	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,309	3,947	11,256	0	8.00
9.00	00900	HOUSEKEEPING	0	15,715	8,487	24,202	0	9.00
10.00	01000	DIETARY	0	14,969	8,084	23,053	0	10.00
11.00	01100	CAFETERIA	0	4,244	2,292	6,536	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,426	770	2,196	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,283	5,553	15,836	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,024	553	1,577	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	57,215	30,900	88,115	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	45,670	24,665	70,335	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,064	23,798	67,862	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,899	15,067	42,966	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,605	1,947	5,552	0	54.01
60.00	06000	LABORATORY	0	16,346	8,828	25,174	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,513	5,137	14,650	0	65.00
65.01	03610	SLEEP LAB	0	901	487	1,388	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,997	3,779	10,776	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,102	5,996	17,098	0	73.00
73.01	03480	ONCOLOGY	0	25,342	13,687	39,029	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	47,604	25,709	73,313	0	88.00
91.00	09100	EMERGENCY	0	41,295	22,302	63,597	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	806,202	435,402	1,241,604	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,482	13,762	39,244	0	192.00
192.01	19201	XPRESS CARE	21,630	0	8,571	30,201	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	14,150	0	14,150	0	193.01
193.02	19302	LEASED SPACE	0	55,379	0	55,379	0	193.02
193.03	19303	UNUSED SPACE	0	4,039	0	4,039	0	193.03
193.04	19304	WELLNESS	0	43,188	23,324	66,512	0	193.04
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)	21,630	948,440	481,059	1,451,129	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	381,910					5.00
6.00	00600	MAINTENANCE & REPAIRS	25,703	280,886				6.00
7.00	00700	OPERATION OF PLANT	7,674	0	7,674			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,374	3,756	105	16,491		8.00
9.00	00900	HOUSEKEEPING	11,254	8,076	226	0	43,758	9.00
10.00	01000	DIETARY	6,959	7,693	215	0	1,251	10.00
11.00	01100	CAFETERIA	127	2,181	61	0	355	11.00
13.00	01300	NURSING ADMINISTRATION	7,478	733	20	0	119	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,636	5,284	148	0	859	16.00
17.00	01700	SOCIAL SERVICE	3,600	526	15	0	86	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,111	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,078	29,400	819	6,882	4,782	30.00
40.00	04000	SUBPROVIDER - IPF	25,146	23,469	655	9,609	3,817	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,753	22,644	632	0	3,683	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,986	14,337	400	0	2,332	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,705	1,853	52	0	301	54.01
60.00	06000	LABORATORY	24,991	8,400	235	0	1,366	60.00
65.00	06500	RESPIRATORY THERAPY	4,868	4,888	137	0	795	65.00
65.01	03610	SLEEP LAB	694	463	13	0	75	65.01
66.00	06600	PHYSICAL THERAPY	2,844	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,037	3,596	100	0	585	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,512	5,705	159	0	928	73.00
73.01	03480	ONCOLOGY	5,368	13,023	364	0	2,118	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31,094	24,463	683	0	3,979	88.00
91.00	09100	EMERGENCY	33,072	21,221	593	0	3,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	362,064	201,711	5,632	16,491	30,882	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,894	13,095	366	0	2,130	192.00
192.01	19201	XPRESS CARE	10,615	8,156	0	0	1,326	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	276	7,272	203	0	1,183	193.01
193.02	19302	LEASED SPACE	1,079	28,459	795	0	4,628	193.02
193.03	19303	UNUSED SPACE	79	0	58	0	0	193.03
193.04	19304	WELLNESS	4,903	22,193	620	0	3,609	193.04
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)	381,910	280,886	7,674	16,491	43,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	39,171					10.00
11.00	01100	CAFETERIA	0	9,260				11.00
13.00	01300	NURSING ADMINISTRATION	0	387	10,933			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44	0	28,807		16.00
17.00	01700	SOCIAL SERVICE	0	193	0	0	5,997	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	60	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,346	1,396	2,613	1,330	2,503	30.00
40.00	04000	SUBPROVIDER - IPF	22,825	1,194	1,875	1,529	3,494	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	597	1,382	1,030	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,173	19	8,798	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	80	90	440	0	54.01
60.00	06000	LABORATORY	0	733	0	4,759	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	212	295	965	0	65.00
65.01	03610	SLEEP LAB	0	0	0	215	0	65.01
66.00	06600	PHYSICAL THERAPY	0	104	0	182	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64	0	696	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	598	0	5,152	0	73.00
73.01	03480	ONCOLOGY	0	240	433	390	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	989	1,061	0	0	88.00
91.00	09100	EMERGENCY	0	1,119	2,905	3,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,171	9,183	10,673	28,807	5,997	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77	205	0	0	192.00
192.01	19201	XPRESS CARE	0	0	55	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	39,171	9,260	10,933	28,807	5,997	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,171					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		184,264	0	184,264		30.00
40.00	04000	SUBPROVIDER - IPF		163,948	0	163,948		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		112,583	0	112,583		50.00
53.00	05300	ANESTHESIOLOGY		35	0	35		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		101,011	0	101,011		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		10,073	0	10,073		54.01
60.00	06000	LABORATORY		65,658	0	65,658		60.00
65.00	06500	RESPIRATORY THERAPY		26,810	0	26,810		65.00
65.01	03610	SLEEP LAB		2,848	0	2,848		65.01
66.00	06600	PHYSICAL THERAPY		3,130	0	3,130		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		22,854	0	22,854		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		107,152	0	107,152		73.00
73.01	03480	ONCOLOGY		60,965	0	60,965		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		135,582	0	135,582		88.00
91.00	09100	EMERGENCY		129,244	0	129,244		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,126,157	0	1,126,157		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		58,011	0	58,011		192.00
192.01	19201	XPRESS CARE		50,353	0	50,353		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	RENAL		23,084	0	23,084		193.01
193.02	19302	LEASED SPACE		90,340	0	90,340		193.02
193.03	19303	UNUSED SPACE		4,176	0	4,176		193.03
193.04	19304	WELLNESS		97,837	0	97,837		193.04
200.00		Cross Foot Adjustments	1,171	1,171	0	1,171		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,171	1,451,129	0	1,451,129		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,756					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		108,714				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,423,588			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,266	30,266	1,575,234	-6,623,328	19,602,025	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	452,193	0	1,319,258	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	393,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	70,520	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	305,777	0	577,654	9.00
10.00	01000	DIETARY	1,827	1,827	183,396	0	357,177	10.00
11.00	01100	CAFETERIA	518	518	0	0	6,536	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	268,222	0	383,811	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	30,725	0	340,601	16.00
17.00	01700	SOCIAL SERVICE	125	125	134,008	0	184,775	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	41,695	0	57,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	966,226	0	1,543,809	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	827,548	0	1,290,649	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,378	5,378	414,061	0	757,237	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	812,750	0	1,590,423	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	55,428	0	87,514	54.01
60.00	06000	LABORATORY	1,995	1,995	507,952	0	1,282,692	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	147,129	0	249,836	65.00
65.01	03610	SLEEP LAB	110	110	304	0	35,606	65.01
66.00	06600	PHYSICAL THERAPY	0	0	72,138	0	145,993	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	44,383	0	361,185	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	414,181	0	3,978,261	73.00
73.01	03480	ONCOLOGY	3,093	3,093	166,666	0	275,499	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	685,571	0	1,595,971	88.00
91.00	09100	EMERGENCY	5,040	5,040	775,511	0	1,697,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,396	98,396	8,881,098	-6,623,328	18,583,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	53,439	0	148,558	192.00
192.01	19201	XPRESS CARE	0	1,937	357,810	0	544,851	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	0	0	0	14,150	193.01
193.02	19302	LEASED SPACE	6,759	0	0	0	55,379	193.02
193.03	19303	UNUSED SPACE	493	0	0	0	4,039	193.03
193.04	19304	WELLNESS	5,271	5,271	131,241	0	251,669	193.04
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)	948,440	481,059	3,459,109		6,623,328	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.193441	4.424996	0.367069		0.337890	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		381,910	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019483	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,711					6.00
7.00	00700	OPERATION OF PLANT	0	65,267				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	2,461			8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	63,901		9.00
10.00	01000	DIETARY	1,827	1,827	0	1,827	2,461	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,027	6,983	1,027	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,434	5,574	1,434	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,378	5,378	0	5,378	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	0	1,161	0	65.00
65.01	03610	SLEEP LAB	110	110	0	110	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	0	1,355	0	73.00
73.01	03480	ONCOLOGY	3,093	3,093	0	3,093	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,907	47,907	2,461	45,097	2,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	0	3,110	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	1,727	0	1,727	0	193.01
193.02	19302	LEASED SPACE	6,759	6,759	0	6,759	0	193.02
193.03	19303	UNUSED SPACE	0	493	0	0	0	193.03
193.04	19304	WELLNESS	5,271	5,271	0	5,271	0	193.04
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)	1,765,022	527,000	125,150	839,071	564,944	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.457736	8.074525	50.853312	13.130796	229.558716	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	280,886	7,674	16,491	43,758	39,171	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.210490	0.117579	6.700935	0.684778	15.916701	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 8:32 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,417,937					11.00
13.00	01300	NURSING ADMINISTRATION	268,222	2,402,603				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,725	0	58,850,762			16.00
17.00	01700	SOCIAL SERVICE	134,008	0	0	2,461		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	41,695	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	966,226	574,392	2,719,687	1,027	0	30.00
40.00	04000	SUBPROVIDER - IPF	827,548	412,191	3,127,660	1,434	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,061	303,674	2,106,855	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	70,568	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	812,750	4,189	17,931,835	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	55,428	19,726	898,969	0	0	54.01
60.00	06000	LABORATORY	507,952	0	9,732,853	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	147,129	64,941	1,972,642	0	0	65.00
65.01	03610	SLEEP LAB	304	0	440,297	0	0	65.01
66.00	06600	PHYSICAL THERAPY	72,138	0	372,798	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,383	0	1,423,455	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	414,181	0	10,534,944	0	0	73.00
73.01	03480	ONCOLOGY	166,666	95,093	797,366	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	685,571	233,234	0	0	0	88.00
91.00	09100	EMERGENCY	775,511	638,159	6,720,833	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,364,498	2,345,599	58,850,762	2,461	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53,439	44,977	0	0	0	192.00
192.01	19201	XPRESS CARE	0	12,027	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	33,434	523,188	515,664	253,864	76,477	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005209	0.217759	0.008762	103.154815	764.770000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,260	10,933	28,807	5,997	1,171	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001443	0.004550	0.000489	2.436814	11.710000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,946,144		2,946,144	0	2,946,144	30.00
40.00	04000	SUBPROVIDER - IPF	2,663,928		2,663,928	0	2,663,928	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,356,177		1,356,177	0	1,356,177	50.00
53.00	05300	ANESTHESIOLOGY	77,095		77,095	0	77,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,452,383		2,452,383	0	2,452,383	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	150,518		150,518	0	150,518	54.01
60.00	06000	LABORATORY	1,899,114		1,899,114	0	1,899,114	60.00
65.00	06500	RESPIRATORY THERAPY	421,781	0	421,781	0	421,781	65.00
65.01	03610	SLEEP LAB	56,739	0	56,739	0	56,739	65.01
66.00	06600	PHYSICAL THERAPY	198,965	0	198,965	0	198,965	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	536,634		536,634	0	536,634	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,481,521		5,481,521	0	5,481,521	73.00
73.01	03480	ONCOLOGY	544,572		544,572	0	544,572	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,466,516		2,466,516	0	2,466,516	88.00
91.00	09100	EMERGENCY	2,713,140		2,713,140	0	2,713,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	366,338		366,338		366,338	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,331,565	0	24,331,565	0	24,331,565	200.00
201.00		Less Observation Beds	366,338		366,338		366,338	201.00
202.00		Total (see instructions)	23,965,227	0	23,965,227	0	23,965,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,076,819		2,076,819			30.00
40.00	04000	SUBPROVIDER - IPF	3,127,660		3,127,660			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,459	2,097,396	2,106,855	0.643697	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	70,568	70,568	1.092492	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	885,594	17,046,241	17,931,835	0.136761	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	8,683	890,286	898,969	0.167434	0.000000	54.01
60.00	06000	LABORATORY	884,410	8,848,443	9,732,853	0.195124	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	499,726	1,472,916	1,972,642	0.213815	0.000000	65.00
65.01	03610	SLEEP LAB	0	440,297	440,297	0.128865	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	336,161	36,637	372,798	0.533707	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,137	1,251,318	1,423,455	0.376994	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	682,984	9,851,960	10,534,944	0.520318	0.000000	73.00
73.01	03480	ONCOLOGY	0	797,366	797,366	0.682964	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,517,574	2,517,574			88.00
91.00	09100	EMERGENCY	18,707	6,702,126	6,720,833	0.403691	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	642,868	642,868	0.569849	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,702,340	52,665,996	61,368,336			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,702,340	52,665,996	61,368,336			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	0.643697		50.00
53.00	05300	ANESTHESIOLOGY	1.092492		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434		54.01
60.00	06000	LABORATORY	0.195124		60.00
65.00	06500	RESPIRATORY THERAPY	0.213815		65.00
65.01	03610	SLEEP LAB	0.128865		65.01
66.00	06600	PHYSICAL THERAPY	0.533707		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318		73.00
73.01	03480	ONCOLOGY	0.682964		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.403691		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	112,583	2,106,855	0.053437	4,729	253	50.00
53.00	05300	ANESTHESIOLOGY	35	70,568	0.000496	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,011	17,931,835	0.005633	457,592	2,578	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	10,073	898,969	0.011205	6,506	73	54.01
60.00	06000	LABORATORY	65,658	9,732,853	0.006746	422,148	2,848	60.00
65.00	06500	RESPIRATORY THERAPY	26,810	1,972,642	0.013591	321,039	4,363	65.00
65.01	03610	SLEEP LAB	2,848	440,297	0.006468	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,130	372,798	0.008396	107,142	900	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,854	1,423,455	0.016055	109,089	1,751	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,152	10,534,944	0.010171	262,415	2,669	73.00
73.01	03480	ONCOLOGY	60,965	797,366	0.076458	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	135,582	2,517,574	0.053854	0	0	88.00
91.00	09100	EMERGENCY	129,244	6,720,833	0.019230	271	5	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,912	642,868	0.035640	0	0	92.00
200.00		Total (lines 50 through 199)	800,857	56,163,857		1,690,931	15,440	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	76,477	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	76,477	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	2,106,855	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	76,477	0	70,568	1.083735	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,931,835	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	898,969	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	9,732,853	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,972,642	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	440,297	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	372,798	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,423,455	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,534,944	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	797,366	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,517,574	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,720,833	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	642,868	0.000000	92.00
200.00		Total (lines 50 through 199)	0	76,477	0	56,163,857		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	4,729	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	457,592	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	6,506	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	422,148	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	321,039	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	107,142	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	109,089	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	262,415	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	271	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)		1,690,931	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		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	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	0.643697	0	1,023,139	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	7,974	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	0	6,454,814	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	0	441,035	0	0	54.01
60.00	06000	LABORATORY	0.195124	0	3,523,254	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	0	715,854	0	0	65.00
65.01	03610	SLEEP LAB	0.128865	0	136,070	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	0	14,210	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	0	558,370	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	0	4,815,959	3,926	0	73.00
73.01	03480	ONCOLOGY	0.682964	0	362,033	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.403691	0	2,089,573	1,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	379,922	0	0	92.00
200.00		Subtotal (see instructions)		0	20,522,207	5,427	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	20,522,207	5,427	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		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	658,592	0		50.00
53.00	05300	ANESTHESIOLOGY	8,712	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	882,767	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	73,844	0		54.01
60.00	06000	LABORATORY	687,471	0		60.00
65.00	06500	RESPIRATORY THERAPY	153,060	0		65.00
65.01	03610	SLEEP LAB	17,535	0		65.01
66.00	06600	PHYSICAL THERAPY	7,584	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,502	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,505,830	2,043		73.00
73.01	03480	ONCOLOGY	247,256	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	843,542	606		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	216,498	0		92.00
200.00		Subtotal (see instructions)	6,513,193	2,649		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,513,193	2,649		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II | Date/Time Prepared: 2/25/2019 8:32 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	112,583	2,106,855	0.053437	0	0	50.00
53.00	05300	ANESTHESIOLOGY	35	70,568	0.000496	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,011	17,931,835	0.005633	112,591	634	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	10,073	898,969	0.011205	0	0	54.01
60.00	06000	LABORATORY	65,658	9,732,853	0.006746	131,099	884	60.00
65.00	06500	RESPIRATORY THERAPY	26,810	1,972,642	0.013591	13,059	177	65.00
65.01	03610	SLEEP LAB	2,848	440,297	0.006468	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,130	372,798	0.008396	13,247	111	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,854	1,423,455	0.016055	6,082	98	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,152	10,534,944	0.010171	133,652	1,359	73.00
73.01	03480	ONCOLOGY	60,965	797,366	0.076458	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	135,582	2,517,574	0.053854	0	0	88.00
91.00	09100	EMERGENCY	129,244	6,720,833	0.019230	709	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	642,868	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	777,945	56,163,857		410,439	3,277	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 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	76,477	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	76,477	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 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	2,106,855	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	76,477	0	70,568	1.083735	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,931,835	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	898,969	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	9,732,853	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,972,642	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	440,297	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	372,798	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,423,455	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,534,944	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	797,366	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,517,574	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,720,833	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	642,868	0.000000	92.00
200.00		Total (lines 50 through 199)	0	76,477	0	56,163,857		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 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	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	112,591	0	805	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	131,099	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	13,059	0	2,115	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	13,247	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,082	0	655	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	133,652	0	683	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	709	0	422	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)		410,439	0	4,680	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
		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	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03610	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	03480	ONCOLOGY	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/25/2019 8:32 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	0.643697	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	805	0	0	110	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	0	0	0	0	54.01
60.00	06000	LABORATORY	0.195124	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	2,115	0	0	452	65.00
65.01	03610	SLEEP LAB	0.128865	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	655	0	0	247	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	683	0	577	355	73.00
73.01	03480	ONCOLOGY	0.682964	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.403691	422	0	0	170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	0	0	0	92.00
200.00		Subtotal (see instructions)		4,680	0	577	1,334	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,680	0	577	1,334	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/25/2019 8:32 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	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03610	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	300	73.00
73.01	03480	ONCOLOGY	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	300	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	300	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.643697	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	0	0	0	0	54.01
60.00	06000	LABORATORY	0.195124	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.128865	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	0	0	418	0	73.00
73.01	03480	ONCOLOGY	0.682964	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.403691	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	418	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	418	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Swing Beds - SNF | Cost

		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	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	217		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	217		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	217		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

	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)	1,164	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	876	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)	739	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	56	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)	166	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	17	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)	49	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	579	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)	56	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)	166	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	149.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	154.38	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,946,144	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)	2,533	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)	7,565	25.00
26.00	Total swing-bed cost (see instructions)	603,724	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,342,420	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,342,420	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)	2,673.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,548,240	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)	1,548,240	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	452,684	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,000,924	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	149,743	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	443,882	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	593,625	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)	137	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,674.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	366,338	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

	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	184,264	2,946,144	0.062544	366,338	22,912	90.00
91.00	Nursing School cost	0	2,946,144	0.000000	366,338	0	91.00
92.00	Allied health cost	0	2,946,144	0.000000	366,338	0	92.00
93.00	All other Medical Education	0	2,946,144	0.000000	366,338	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 8:32 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)	1,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,434	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,434	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)	741	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,663,928	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,663,928	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,663,928	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,857.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,376,548	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)	1,376,548	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 8:32 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)	122,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,499,510	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,277	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,277	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,496,233	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1

Component CCN: 14-M315 | Date/Time Prepared: 2/25/2019 8:32 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	0	2,663,928	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,663,928	0.000000	0	0	91.00
92.00	Allied health cost	0	2,663,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,663,928	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,380,482		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.643697	4,729	3,044	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	457,592	62,581	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	6,506	1,089	54.01
60.00	06000	LABORATORY	0.195124	422,148	82,371	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	321,039	68,643	65.00
65.01	03610	SLEEP LAB	0.128865	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	107,142	57,182	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	109,089	41,126	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	262,415	136,539	73.00
73.01	03480	ONCOLOGY	0.682964	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.403691	271	109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,690,931	452,684	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)		1,690,931		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 8:32 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		1,610,419		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.643697	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	112,591	15,398	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	0	0	54.01
60.00	06000	LABORATORY	0.195124	131,099	25,581	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	13,059	2,792	65.00
65.01	03610	SLEEP LAB	0.128865	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	13,247	7,070	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	6,082	2,293	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	133,652	69,542	73.00
73.01	03480	ONCOLOGY	0.682964	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.403691	709	286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		410,439	122,962	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)		410,439		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.643697	1,354	872	50.00
53.00	05300	ANESTHESIOLOGY	1.092492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136761	18,359	2,511	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.167434	0	0	54.01
60.00	06000	LABORATORY	0.195124	61,011	11,905	60.00
65.00	06500	RESPIRATORY THERAPY	0.213815	57,401	12,273	65.00
65.01	03610	SLEEP LAB	0.128865	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.533707	132,541	70,738	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376994	19,281	7,269	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.520318	59,200	30,803	73.00
73.01	03480	ONCOLOGY	0.682964	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.403691	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569849	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		349,147	136,371	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)		349,147		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,515,842	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,515,842	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,581,000	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	38,064	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,395,738	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)	3,147,198	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)	3,147,198	30.00
31.00	Primary payer payments	263	31.00
32.00	Subtotal (line 30 minus line 31)	3,146,935	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)	353,235	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	229,603	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	280,960	36.00
37.00	Subtotal (see instructions)	3,376,538	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)	3,376,538	40.00
40.01	Sequestration adjustment (see instructions)	67,531	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,798,509	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-489,502	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: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	300	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,334	2.00
3.00	OPPS payments	266	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)	300	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	577	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)	577	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)	577	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	277	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)	300	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)	266	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)	22	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)	544	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)	544	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	544	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)	544	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)	544	40.00
40.01	Sequestration adjustment (see instructions)	11	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	483	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	50	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: 14-1315 Component CCN: 14-M315	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Subprovider - IPF	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,353,910		3,799,964	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/26/2018	49,540		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	04/26/2018	1,455	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		49,540		-1,455	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,403,450		3,798,509	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		406,761		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		489,502	6.02
7.00	Total Medicare program liability (see instructions)		1,810,211		3,309,007	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: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2019 8:32 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		778,780		483	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)		778,780		483	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		20,408		50	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		799,188		533	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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		577,961		410	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/26/2018	19,034		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)		19,034		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)		596,995		410	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		126,386		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		239	6.02
7.00	Total Medicare program liability (see instructions)		723,381		171	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: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 2/25/2019 8:32 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	599,561	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)	137,735	219	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	222	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)	737,296	219	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	737,296	219	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)	737,296	219	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	329	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		175	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	736,967	175	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)	1,811	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,177	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,811	0	18.00
19.00	Total (see instructions)	738,144	175	19.00
19.01	Sequestration adjustment (see instructions)	14,763	4	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	596,995	410	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)	126,386	-239	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: 14-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/25/2019 8:32 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,000,924	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,000,924	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,020,933	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,020,933	19.00
20.00	Deductibles (exclude professional component)	190,564	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,830,369	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,830,369	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25,823	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,785	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,615	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,847,154	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,847,154	30.00
30.01	Sequestration adjustment (see instructions)	36,943	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,403,450	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	406,761	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/25/2019 8:32 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)	725,824	1.00
2.00	Net IPF PPS Outlier Payments	163,701	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	3.928767	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)	889,525	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)	889,525	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	889,525	18.00
19.00	Deductibles	89,492	19.00
20.00	Subtotal (line 18 minus line 19)	800,033	20.00
21.00	Coinsurance	5,360	21.00
22.00	Subtotal (line 20 minus line 21)	794,673	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32,039	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	20,825	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,967	25.00
26.00	Subtotal (sum of lines 22 and 24)	815,498	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)	815,498	31.00
31.01	Sequestration adjustment (see instructions)	16,310	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	778,780	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)	20,408	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	163,701	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: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/25/2019 8:32 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	9,830,574	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	12,141,755	0	0	0	4.00
5.00	Other receivable	-345,613	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,486,000	0	0	0	6.00
7.00	Inventory	696,544	0	0	0	7.00
8.00	Prepaid expenses	174,374	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)	14,011,634	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	279,691	0	0	0	12.00
13.00	Land improvements	533,487	0	0	0	13.00
14.00	Accumulated depreciation	-376,667	0	0	0	14.00
15.00	Buildings	16,074,466	0	0	0	15.00
16.00	Accumulated depreciation	-6,142,728	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	7,588,489	0	0	0	23.00
24.00	Accumulated depreciation	-5,446,504	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,510,234	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	123,041	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	123,041	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,644,909	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,103,895	0	0	0	37.00
38.00	Salaries, wages, and fees payable	962,442	0	0	0	38.00
39.00	Payroll taxes payable	171,972	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	226,456	0	0	0	43.00
44.00	Other current liabilities	2,115,184	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,579,949	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,157,960	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	100,033	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,257,993	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,837,942	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,806,967				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)	18,806,967	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,644,909	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/25/2019 8:32 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		14,982,083		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,824,882				2.00
3.00	Total (sum of line 1 and line 2)		18,806,965		0		3.00
4.00	ROUNDING	2		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)		2		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,806,967		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,806,967		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/25/2019 8:32 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,778,102		1,778,102	1.00
2.00	SUBPROVIDER - IPF	3,211,546		3,211,546	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	233,630		233,630	5.00
6.00	Swing bed - NF	69,458		69,458	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)	5,292,736		5,292,736	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)	5,292,736		5,292,736	17.00
18.00	Ancillary services	3,734,576	0	3,734,576	18.00
19.00	Outpatient services	0	54,699,211	54,699,211	19.00
20.00	RURAL HEALTH CLINIC	0	2,517,574	2,517,574	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICE	0	314,883	314,883	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,027,312	57,531,668	66,558,980	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,454,440		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)		26,454,440		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/25/2019 8:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,558,980	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,269,055	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,289,925	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,454,440	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,835,485	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	5,131	6.00
7.00	Income from investments	7,680	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	49,486	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	130,067	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	797,033	24.00
25.00	Total other income (sum of lines 6-24)	989,397	25.00
26.00	Total (line 5 plus line 25)	3,824,882	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,824,882	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/25/2019 8:32 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	17,788	0	17,788	0	17,788	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	259,781	0	259,781	0	259,781	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	295,996	0	295,996	0	295,996	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)	573,565	0	573,565	0	573,565	10.00
11.00	Physician Services Under Agreement	0	357,352	357,352	0	357,352	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	199,325	199,325	0	199,325	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	556,677	556,677	0	556,677	14.00
15.00	Medical Supplies	0	1,695	1,695	-1,695	0	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	46,432	46,432	0	46,432	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,127	48,127	-1,695	46,432	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	573,565	604,804	1,178,369	-1,695	1,176,674	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	384	384	-165	219	29.00
30.00	Administrative Costs	112,006	30,883	142,889	0	142,889	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	112,006	31,267	143,273	-165	143,108	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	685,571	636,071	1,321,642	-1,860	1,319,782	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/25/2019 8:32 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	17,788		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	259,781		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	295,996		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	573,565		10.00
11.00	Physician Services Under Agreement	-44,989	312,363		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	-3,095	196,230		13.00
14.00	Subtotal (sum of lines 11 through 13)	-48,084	508,593		14.00
15.00	Medical Supplies	0	0		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	46,432		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	46,432		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-48,084	1,128,590		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-52	167		29.00
30.00	Administrative Costs	-640	142,249		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-692	142,416		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-48,776	1,271,006		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/25/2019 8:32 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.86	2,272	4,200	3,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.95	5,974	2,100	4,095		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.81	8,246		7,707	8,246	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	685			685	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.81	8,931			8,931	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)					1,128,590	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,128,590	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					142,416	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,195,510	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,337,926	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,337,926	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,337,926	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,466,516	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/25/2019 8:32 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)		2,466,516	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		54,883	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,411,633	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,931	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)		8,931	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		270.03	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	270.03	270.03	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	554	1,814	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	149,597	489,834	11.00
12.00	Program covered visits for mental health services (from contractor records)	5	43	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,350	11,611	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,350	11,611	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	652,392	16.00
16.01	Total program charges (see instructions)(from contractor's records)		570,405	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,682	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,068	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.)		488,176	16.04
16.05	Total program cost (see instructions)	0	491,244	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,104	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		105,724	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		491,244	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		30,850	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		522,094	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)		522,094	26.00
26.01	Sequestration adjustment (see instructions)		10,442	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		421,579	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)		90,073	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: 14-1315 Component CCN: 14-3482	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/25/2019 8:32 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)	573,565	573,565	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000807	0.003125	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	463	1,792	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	16,555	6,302	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	17,018	8,094	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,128,590	1,128,590	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,337,926	1,337,926	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015079	0.007172	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	20,175	9,596	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	37,193	17,690	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	118	457	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	315.19	38.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	70	227	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	22,063	8,787	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)		54,883	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)		30,850	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/25/2019 8:32 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		463,044	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		04/26/2018	41,465	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)		-41,465	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		421,579	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		90,073	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		511,652	7.00

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