

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: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 11:11 am
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PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

6. Date Received:
7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

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

Date: 5/29/2019 Time: 11:11 am

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 HOOPESTON COMMUNITY MEMORIAL HOSPITAL (14-1316) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	200,115	653,127	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	176,915	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		973,630		0	10.00
200.00 Total	0	377,030	1,626,757	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: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:11 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00			
1.00	Street: 701 EAST ORANGE	PO Box:		Zip Code: 60942		County: VERMILION			
2.00	City: HOOPESTON	State: IL							

	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	HOOPESTON COMMUNITY MEMORIAL HOSPITAL	141316	19180	1	11/01/2001	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HOOPESTON CMH SWING BED	14Z316	19180		11/01/2001	N	0	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	HOOPESTON MEDICAL CENTER RHC	143448	19180		04/01/1998	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
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)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00
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Inpatient PPS Information									
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00
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.		N	3					23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1316			Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:11 am		
		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	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.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2019 11:11 am

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	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	N	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	N	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	N	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	N	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.		N		108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00	
					1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00	
					1.00	2.00	3.00	
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				2			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	411,059		0		0		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:11 am	
		1.00	2.00				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H077			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: CARLE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00450		141.00	
142.00	Street: 611 WEST PARK STREET	PO Box:				142.00	
143.00	City: URBANA	State: IL		Zip Code: 61801		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
161.10	CORF	N		N		N	
161.20	OUTPATIENT PHYSICAL THERAPY	N		N		N	
161.30	OUTPATIENT OCCUPATIONAL THERAPY	N		N		N	
161.40	OUTPATIENT SPEECH PATHOLOGY	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	88,768				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 11:11 am	
			Beginning 1.00	Ending 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)		01/01/2015	12/31/2015	170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:11 am	
		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				
		1.00	2.00				
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				
		1.00	2.00				
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.	N					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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/01/2019	Y	03/26/2019		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 11:11 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			Y	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.	GARY		ZEMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 EXT. 112		GARY.ZEMAN@SRINC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2019 11:11 am

		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.	VICE PRESIDENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 11:11 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	23,920.00	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)		22	8,030	23,920.00	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)		22	8,030	23,920.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 11:11 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	447	71	816			1.00
2.00 HMO and other (see instructions)	246	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	170	0	170			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	148			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	617	71	1,134			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)	617	71	1,134	0.00	99.30	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RHC (CONSOLIDATED)	32,820	51,111	176,680	0.00	179.66	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	278.96	27.00
28.00 Observation Bed Days		0	751			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 11:11 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	167	20	373	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	167	20	373	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-7

Date/Time Prepared:
5/29/2019 11:11 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/01/2001	2.00

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-7

Date/Time Prepared:
5/29/2019 11:11 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).				201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1316 Component CCN: 14-3448		Period: From 01/01/2018 To 12/31/2018		Worksheet S-8 Date/Time Prepared: 5/29/2019 11:11 am	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		801 EAST ORANGE STREET		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		HOOPESTON IL 60452		2.00	
				1.00			
3.00	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	
4.00	4.00	Source of Federal Funds				4.00	
5.00	5.00	Community Health Center (Section 330(d), PHS Act)				5.00	
6.00	6.00	Migrant Health Center (Section 329(d), PHS Act)				6.00	
7.00	7.00	Health Services for the Homeless (Section 340(d), PHS Act)				7.00	
8.00	8.00	Appalachian Regional Commission				8.00	
9.00	9.00	Look-Alikes				9.00	
9.00	9.00	OTHER				9.00	
				1.00		2.00	
10.00	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	
				Sunday		Monday	
		from to		from to		Tuesday from	
		1.00 2.00		3.00 4.00		5.00	
11.00	11.00	Facility hours of operations (1) CLINIC		09:00 08:00		20:00 08:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
13.00	13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y		8	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number		CHARLOTTE RUSSEL		143448	
14.01	14.01			CISSNA PARK		143485	
14.02	14.02			ROSSVILLE		143496	
14.03	14.03			ROBERTS CLINIC		148521	
14.04	14.04			MILFORD CLINIC		148526	
14.05	14.05			DANVILLE CLINIC		148531	
14.06	14.06			CARLE AT TUSCOLA		148533	
14.07	14.07			CARLE MATTOON		148544	
				XVIIII		XIX	
		Y/N V		3.00		4.00	
		1.00 2.00				Total Visits	
15.00	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)					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1316
Component CCN: 14-3448

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8

Date/Time Prepared:
5/29/2019 11:11 am

		RHC I			Cost		
		County					
		4.00					
2.00	City, State, ZIP Code, County	VERMILLION			2.00		
		Tuesday		Wednesday		Thursday	
		to		to		to	
		6.00		7.00		8.00	
		9.00		10.00			
Facility hours of operations (1)							
11.00	CLINIC	20:00	08:00	20:00	08:00	20:00	11.00
		Friday		Saturday			
		from		from		to	
		11.00		12.00		13.00	
		14.00					
Facility hours of operations (1)							
11.00	CLINIC	08:00	20:00	09:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 11:11 am
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				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)			0.486542	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			8,966,570	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			31,466,760	6.00	
7.00	Medicaid cost (line 1 times line 6)			15,309,900	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)			6,343,330	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)			6,343,330	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)	5,690,309	0	5,690,309	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,768,574	0	2,768,574	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	2,768,574	0	2,768,574	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)			1,612,288	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			577,383	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			888,282	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			724,006	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			663,158	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,431,732	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,775,062	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet A		
Date/Time Prepared: 5/29/2019 11:11 am								
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		1,111,012	1,111,012	498,035	1,609,047	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		879,717	879,717	0	879,717	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	477,192	11,223,212	11,700,404	1,582,064	13,282,468	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	502,520	978,553	1,481,073	14,182	1,495,255	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	75,043	75,043	8.00
9.00	00900	HOUSEKEEPING	184,908	201,250	386,158	-75,043	311,115	9.00
10.00	01000	DIETARY	138,245	181,623	319,868	0	319,868	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	257,005	87,165	344,170	0	344,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	124,723	124,723	-94,455	30,268	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	988,928	527,512	1,516,440	0	1,516,440	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	426,937	401,297	828,234	-36,486	791,748	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	848,229	1,423,265	2,271,494	0	2,271,494	54.00
60.00	06000	LABORATORY	596,543	1,269,378	1,865,921	0	1,865,921	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	416,190	172,450	588,640	0	588,640	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	94,455	94,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,486	36,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,954	735,211	885,165	0	885,165	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,292,480	20,622,052	30,914,532	-1,982,907	28,931,625	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,190,001	2,325,290	3,515,291	-111,374	3,403,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,469,132	42,263,710	58,732,842	0	58,732,842	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	3,539,845	3,539,845	0	3,539,845	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,469,132	45,803,555	62,272,687	0	62,272,687	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A
Date/Time Prepared:
5/29/2019 11:11 am

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	4,775,334	6,384,381	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	879,717	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	626,823	626,823	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-852,371	12,430,097	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,495,255	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	75,043	8.00
9.00	00900	HOUSEKEEPING	0	311,115	9.00
10.00	01000	DIETARY	-66,175	253,693	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	344,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,268	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-180,134	1,336,306	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	791,748	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,710	2,360,204	54.00
60.00	06000	LABORATORY	84,621	1,950,542	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	588,640	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	94,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,038	1,013,203	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	79,503	29,011,128	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,371,597	2,032,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,312,752	62,045,594	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	RETAIL PHARMACY	0	3,539,845	192.01
193.01	19301	MATTOON CLINIC	0	0	193.01
194.00	07950	FOUNDATION	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	3,312,752	65,585,439	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	491,701	1.00	
	TOTALS		0	491,701		
B - SURGERY SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	94,455	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	36,486	2.00	
	TOTALS		0	130,941		
C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,334	1.00	
	TOTALS		0	6,334		
D - UTILITY EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	14,182	1.00	
	TOTALS		0	14,182		
F - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	111,374	1.00	
	TOTALS		0	111,374		
G - RHC ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,285,237	683,488	1.00	
	TOTALS		1,285,237	683,488		
H - LAUNDRY EXPENSE						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	75,043	1.00	
	TOTALS		0	75,043		
500.00	Grand Total: Increases		1,285,237	1,513,063	500.00	

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	491,701	11	1.00	
	TOTALS		0	491,701			
B - SURGERY SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	94,455	0	1.00	
2.00	OPERATING ROOM	50.00	0	36,486	0	2.00	
	TOTALS		0	130,941			
C - CAPITAL INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,334	11	1.00	
	TOTALS		0	6,334			
D - UTILITY EXPENSE							
1.00	RURAL HEALTH CLINIC	88.00	0	14,182	0	1.00	
	TOTALS		0	14,182			
F - INSURANCE EXPENSE							
1.00	EMERGENCY	91.00	0	111,374	0	1.00	
	TOTALS		0	111,374			
G - RHC ADMIN							
1.00	RURAL HEALTH CLINIC	88.00	1,285,237	683,488	0	1.00	
	TOTALS		1,285,237	683,488			
H - LAUNDRY EXPENSE							
1.00	HOUSEKEEPING	9.00	0	75,043	0	1.00	
	TOTALS		0	75,043			
500.00	Grand Total: Decreases		1,285,237	1,513,063		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2019 11:11 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	104,595	0	0	0	1.00
2.00	Land Improvements	1,081,601	25,467	0	25,467	2.00
3.00	Buildings and Fixtures	11,314,594	279,594	0	279,594	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,735,646	789,141	0	789,141	5.00
6.00	Movable Equipment	9,866,735	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,103,171	1,094,202	0	1,094,202	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,103,171	1,094,202	0	1,094,202	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	104,595	0			1.00
2.00	Land Improvements	1,107,068	0			2.00
3.00	Buildings and Fixtures	11,594,188	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	2,524,787	0			5.00
6.00	Movable Equipment	9,866,735	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	25,197,373	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	25,197,373	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2019 11:11 am

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	1,111,012	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	879,717	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,990,729	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	1,111,012				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	879,717				2.00
3.00	Total (sum of lines 1-2)	0	1,990,729				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	15,330,638	0	15,330,638	0.608422	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,866,735	0	9,866,735	0.391578	0	2.00
3.00	Total (sum of lines 1-2)	25,197,373	0	25,197,373	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,901,348	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	879,717	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,781,065	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	483,033	0	0	0	6,384,381	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	879,717	2.00
3.00	Total (sum of lines 1-2)	483,033	0	0	0	7,264,098	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8

Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-15,002	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		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	-1,563,967			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	5,861,139			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-20,887	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees 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		0		0.00	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	*** Cost Center Deleted ***	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

Provider CCN: 14-1316
 Period: From 01/01/2018 To 12/31/2018
 Worksheet A-8
 Date/Time Prepared: 5/29/2019 11:11 am

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
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 CATERING	B	-34,985	DIETARY		10.00	0 33.00
35.00 LOBBYING EXPENSE	A	-10,074	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 OTHER REVENUE	B	-14,101	RURAL HEALTH CLINIC		88.00	0 36.00
39.00 VENDING REVENUE	B	-13,872	DIETARY		10.00	0 39.00
40.00 OTHER INCOME	B	-2,291	ADMINISTRATIVE & GENERAL		5.00	0 40.00
41.00 PROVIDER TAX	A	-880,749	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00 WORKERS COMP EXPENSE	A	-55,355	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00 BILLING REVENUE	B	-15,990	ADMINISTRATIVE & GENERAL		5.00	0 43.00
45.00 CPG BENEFITS AT COST	A	78,886	RURAL HEALTH CLINIC		88.00	0 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,312,752				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: 14-1316
 Period: From 01/01/2018 To 12/31/2018
 Worksheet A-8-1
 Date/Time Prepared: 5/29/2019 11:11 am

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	MANAGEMENT FEES	8,989,814	8,877,726 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL	4,790,336	0 2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	CARLE SERVICES	616,992	528,282 3.00
3.01	60.00	LABORATORY	CARLE SERVICES	673,653	576,796 3.01
3.02	88.00	RURAL HEALTH CLINIC	CARLE SERVICES	102,368	87,650 3.02
3.03	10.00	DIETARY	CARLE SERVICES	24,821	21,252 3.03
3.12	73.00	DRUGS CHARGED TO PATIENTS	CARLE DRUG COSTS	757,749	648,801 3.12
3.13	73.00	DRUGS CHARGED TO PATIENTS	CARLE PHARMACISTS	132,774	113,684 3.13
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CARLE	626,823	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,715,330	10,854,191 5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-1

Date/Time Prepared:
5/29/2019 11:11 am

	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	112,088	0		1.00
2.00	4,790,336	9		2.00
3.00	88,710	0		3.00
3.01	96,857	0		3.01
3.02	14,718	0		3.02
3.03	3,569	0		3.03
3.12	108,948	0		3.12
3.13	19,090	0		3.13
4.00	626,823	0		4.00
5.00	5,861,139			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			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-2
Date/Time Prepared:
5/29/2019 11:11 am

	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	180,134	180,134	0	0	0	3.00
4.00	91.00	EMERGENCY	1,371,597	1,371,597	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	60.00	LABORATORY	12,236	12,236	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,563,967	1,563,967	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	60.00	LABORATORY	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	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	180,134		3.00
4.00	91.00	EMERGENCY	0	0	0	1,371,597		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	60.00	LABORATORY	0	0	0	12,236		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	1,563,967		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,384,381	6,384,381			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	879,717		879,717		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	626,823	0	0	626,823	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,430,097	465,084	64,085	67,078	13,026,344
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	1,495,255	2,213,321	304,977	19,126	4,032,679
8.00 00800	LAUNDRY & LINEN SERVICE	75,043	9,795	1,350	0	86,188
9.00 00900	HOUSEKEEPING	311,115	133,775	18,433	7,038	470,361
10.00 01000	DIETARY	253,693	178,578	24,607	5,262	462,140
11.00 01100	CAFETERIA	0	42,627	5,874	0	48,501
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	344,170	156,721	21,595	9,782	532,268
14.00 01400	CENTRAL SERVICES & SUPPLY	30,268	0	0	0	30,268
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	80,265	11,060	0	91,325
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,336,306	1,134,594	156,338	37,639	2,664,877
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	791,748	626,611	86,342	16,249	1,520,950
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,360,204	308,363	42,490	32,284	2,743,341
60.00 06000	LABORATORY	1,950,542	159,351	21,957	22,704	2,154,554
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	588,640	81,444	11,222	15,840	697,146
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,455	0	0	0	94,455
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	36,486	0	0	0	36,486
73.00 07300	DRUGS CHARGED TO PATIENTS	1,013,203	5,260	725	5,707	1,024,895
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	29,011,128	428,624	59,061	342,823	29,841,636
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	2,032,320	359,968	49,601	45,291	2,487,180
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	62,045,594	6,384,381	879,717	626,823	62,045,594
NONREIMBURSABLE COST CENTERS						
192.01 19201	RETAIL PHARMACY	3,539,845	0	0	0	3,539,845
193.01 19301	MATTOON CLINIC	0	0	0	0	0
194.00 07950	FOUNDATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	65,585,439	6,384,381	879,717	626,823	65,585,439

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet B
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	857,688					10.00
11.00	01100	0	127,599				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	2,866	0	913,667		13.00
14.00	01400	0	0	0	0	37,770	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	857,688	22,432	0	389,382	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,308	0	92,134	0	50.00
54.00	05400	0	16,712	0	0	0	54.00
60.00	06000	0	14,630	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	0	8,672	0	0	0	66.00
71.00	07100	0	0	0	0	27,246	71.00
72.00	07200	0	0	0	0	10,524	72.00
73.00	07300	0	342	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	31,741	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	24,896	0	432,151	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		857,688	127,599	0	913,667	37,770	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	0	0	0	0	0	192.01
193.01	19301	0	0	0	0	0	193.01
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		857,688	127,599	0	913,667	37,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	0					15.00
16.00	01600	0	240,264				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
23.00	02300	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	56,394	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	18,754	0	0	0	50.00
54.00	05400	0	44,590	0	0	0	54.00
60.00	06000	0	31,476	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	0	13,771	0	0	0	66.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	20,459	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	54,820	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		0	240,264	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	0	0	0	0	0	192.01
193.01	19301	0	0	0	0	0	193.01
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	240,264	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	6,557,480	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	3,000,133	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,969,796	0 54.00
60.00 06000	LABORATORY	0	0	0	2,985,403	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
66.00 06600	PHYSICAL THERAPY	0	0	0	1,020,530	0 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	145,111	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,053	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,287,527	0 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	37,964,321	0 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	0	0	4,181,918	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	61,168,272	0 118.00
NONREIMBURSABLE COST CENTERS						
192.01 19201	RETAIL PHARMACY	0	0	0	4,417,167	0 192.01
193.01 19301	MATTOON CLINIC	0	0	0	0	0 193.01
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	65,585,439	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Total	
		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
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	6,557,480	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	3,000,133	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,969,796	54.00
60.00	06000 LABORATORY	2,985,403	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
66.00	06600 PHYSICAL THERAPY	1,020,530	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	145,111	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,053	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,287,527	73.00
76.97	07697 CARDIAC REHABILITATION	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	37,964,321	88.00
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	4,181,918	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	61,168,272	118.00
NONREIMBURSABLE COST CENTERS			
192.01	19201 RETAIL PHARMACY	4,417,167	192.01
193.01	19301 MATTOON CLINIC	0	193.01
194.00	07950 FOUNDATION	0	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	65,585,439	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
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	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	465,084	64,085	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	2,213,321	304,977	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,795	1,350	8.00
9.00 00900	HOUSEKEEPING	0	133,775	18,433	9.00
10.00 01000	DIETARY	0	178,578	24,607	10.00
11.00 01100	CAFETERIA	0	42,627	5,874	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	156,721	21,595	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	80,265	11,060	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,134,594	156,338	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	626,611	86,342	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	308,363	42,490	54.00
60.00 06000	LABORATORY	0	159,351	21,957	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
66.00 06600	PHYSICAL THERAPY	0	81,444	11,222	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	5,260	725	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	428,624	59,061	88.00
90.00 09000	CLINIC	0	0	0	90.00
91.00 09100	EMERGENCY	0	359,968	49,601	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6,384,381	879,717	118.00
NONREIMBURSABLE COST CENTERS					
192.01 19201	RETAIL PHARMACY	0	0	0	192.01
193.01 19301	MATTOON CLINIC	0	0	0	193.01
194.00 07950	FOUNDATION	0	0	0	194.00
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	6,384,381	879,717	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am		
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	529,169				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	40,601	0	2,558,899		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	868	0	6,763	18,776	8.00
9.00	00900	HOUSEKEEPING	4,736	0	92,369	0	249,313
10.00	01000	DIETARY	4,653	0	123,305	0	12,498
11.00	01100	CAFETERIA	488	0	29,433	0	2,983
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	5,359	0	108,212	0	10,968
14.00	01400	CENTRAL SERVICES & SUPPLY	305	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	919	0	55,421	0	5,617
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,830	0	783,414	18,776	79,404
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,313	0	432,662	0	43,853
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,620	0	212,918	0	21,581
60.00	06000	LABORATORY	21,692	0	110,029	0	11,152
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	7,019	0	56,235	0	5,700
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	951	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	367	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	10,319	0	3,632	0	368
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	300,449	0	295,956	0	29,997
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	25,041	0	248,550	0	25,192
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,530	0	2,558,899	18,776	249,313
NONREIMBURSABLE COST CENTERS							
192.01	19201	RETAIL PHARMACY	35,639	0	0	0	0
193.01	19301	MATTOON CLINIC	0	0	0	0	0
194.00	07950	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	529,169	0	2,558,899	18,776	249,313

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	343,641					10.00
11.00	01100	0	81,405				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	1,829	0	304,684		13.00
14.00	01400	0	0	0	0	305	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	343,641	14,311	0	129,849	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	3,386	0	30,724	0	50.00
54.00	05400	0	10,662	0	0	0	54.00
60.00	06000	0	9,333	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	0	5,532	0	0	0	66.00
71.00	07100	0	0	0	0	220	71.00
72.00	07200	0	0	0	0	85	72.00
73.00	07300	0	218	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	20,251	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	15,883	0	144,111	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		343,641	81,405	0	304,684	305	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	0	0	0	0	0	192.01
193.01	19301	0	0	0	0	0	193.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		343,641	81,405	0	304,684	305	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am		
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
			15.00	16.00	17.00	19.00	20.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	153,282			16.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	35,977	0		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,965	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,448	0		54.00
60.00	06000	LABORATORY	0	20,081	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
66.00	06600	PHYSICAL THERAPY	0	8,785	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,052	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	34,974	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	153,282	0	0	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	RETAIL PHARMACY	0	0	0		192.01
193.01	19301	MATTOON CLINIC	0	0	0		193.01
194.00	07950	FOUNDATION	0	0	0		194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	153,282	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00	23.00			
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				2,723,134	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				1,250,856	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				652,082	0 54.00
60.00 06000	LABORATORY				353,595	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0 62.30
66.00 06600	PHYSICAL THERAPY				175,937	0 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT				1,171	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				452	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				20,522	0 73.00
76.97 07697	CARDIAC REHABILITATION				0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY				0	0 76.98
76.99 07699	LITHOTRIPSY				0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC				1,147,390	0 88.00
90.00 09000	CLINIC				0	0 90.00
91.00 09100	EMERGENCY				903,320	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF				0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY				0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY				0	0 99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	7,228,459	0 118.00
NONREIMBURSABLE COST CENTERS						
192.01 19201	RETAIL PHARMACY				35,639	0 192.01
193.01 19301	MATTOON CLINIC				0	0 193.01
194.00 07950	FOUNDATION				0	0 194.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	7,264,098	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Total	
		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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,723,134
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,250,856
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,082
60.00	06000	LABORATORY	353,595
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0
66.00	06600	PHYSICAL THERAPY	175,937
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,171
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	452
73.00	07300	DRUGS CHARGED TO PATIENTS	20,522
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIpsy	0
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,147,390
90.00	09000	CLINIC	0
91.00	09100	EMERGENCY	903,320
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,228,459
NONREIMBURSABLE COST CENTERS			
192.01	19201	RETAIL PHARMACY	35,639
193.01	19301	MATTOON CLINIC	0
194.00	07950	FOUNDATION	0
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	7,264,098

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	70,394				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		70,394			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,469,132		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,128	5,128	1,762,429	-13,026,344	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	24,404	24,404	502,520	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	108	108	0	0	8.00
9.00 00900	HOUSEKEEPING	1,475	1,475	184,908	0	9.00
10.00 01000	DIETARY	1,969	1,969	138,245	0	10.00
11.00 01100	CAFETERIA	470	470	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,728	1,728	257,005	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	885	885	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,510	12,510	988,928	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,909	6,909	426,937	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,400	3,400	848,229	0	54.00
60.00 06000	LABORATORY	1,757	1,757	596,543	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00 06600	PHYSICAL THERAPY	898	898	416,190	0	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	58	58	149,954	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,726	4,726	9,007,243	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	3,969	3,969	1,190,001	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	70,394	70,394	16,469,132	-13,026,344	118.00
NONREIMBURSABLE COST CENTERS						
192.01 19201	RETAIL PHARMACY	0	0	0	0	192.01
193.01 19301	MATTOON CLINIC	0	0	0	0	193.01
194.00 07950	FOUNDATION	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,384,381	879,717	626,823	13,026,344	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	90.694960	12.497045	0.038060	0.247842	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	529,169	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.010068	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: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet B-1	
Date/Time Prepared: 5/29/2019 11:11 am							
Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
	6.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
6.00 00600	MAINTENANCE & REPAIRS	0					6.00
7.00 00700	OPERATION OF PLANT	0	40,862				7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	108	100			8.00
9.00 00900	HOUSEKEEPING	0	1,475	0	39,279		9.00
10.00 01000	DIETARY	0	1,969	0	1,969	100	10.00
11.00 01100	CAFETERIA	0	470	0	470	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	1,728	0	1,728	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	885	0	885	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	12,510	100	12,510	100	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	6,909	0	6,909	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	3,400	0	3,400	0	54.00
60.00 06000	LABORATORY	0	1,757	0	1,757	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00 06600	PHYSICAL THERAPY	0	898	0	898	0	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	58	0	58	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	4,726	0	4,726	0	88.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	3,969	0	3,969	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	40,862	100	39,279	100	118.00
NONREIMBURSABLE COST CENTERS							
192.01 19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01 19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00 07950	FOUNDATION	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	5,032,146	120,849	768,582	857,688	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	123.149772	1,208.490000	19.567250	8,576.880000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	2,558,899	18,776	249,313	343,641	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	62.622950	187.760000	6.347234	3,436.410000	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: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	188,403					11.00
12.00	01200	0	0				12.00
13.00	01300	4,232	0	77,717			13.00
14.00	01400	0	0	0	130,941		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,121	0	33,121	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,837	0	7,837	0	0	50.00
54.00	05400	24,675	0	0	0	0	54.00
60.00	06000	21,601	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	12,804	0	0	0	0	66.00
71.00	07100	0	0	0	94,455	0	71.00
72.00	07200	0	0	0	36,486	0	72.00
73.00	07300	505	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	46,869	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	36,759	0	36,759	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		188,403	0	77,717	130,941	0	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	0	0	0	0	0	192.01
193.01	19301	0	0	0	0	0	193.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		127,599	0	913,667	37,770	0	202.00
203.00		0.677266	0.000000	11.756334	0.288451	0.000000	203.00
204.00		81,405	0	304,684	305	0	204.00
205.00		0.432079	0.000000	3.920429	0.002329	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00		
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
12.00 01200 MAINTENANCE OF PERSONNEL							12.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
15.00 01500 PHARMACY							15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	9,160						16.00
17.00 01700 SOCIAL SERVICE	0	0					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
20.00 02000 NURSING SCHOOL	0	0		0			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,150	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	715	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,700	0	0	0	0	0	54.00
60.00 06000 LABORATORY	1,200	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
66.00 06600 PHYSICAL THERAPY	525	0	0	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	780	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	2,090	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9,160	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
192.01 19201 RETAIL PHARMACY	0	0	0	0	0	0	192.01
193.01 19301 MATTOON CLINIC	0	0	0	0	0	0	193.01
194.00 07950 FOUNDATION	0	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	240,264	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26.229694	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	153,282	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	16.733843	0.000000	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00		
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
12.00 01200	MAINTENANCE OF PERSONNEL		12.00
13.00 01300	NURSING ADMINISTRATION		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY		14.00
15.00 01500	PHARMACY		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY		16.00
17.00 01700	SOCIAL SERVICE		17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00 02000	NURSING SCHOOL		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000	ADULTS & PEDIATRICS	0	30.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000	OPERATING ROOM	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00 06000	LABORATORY	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
66.00 06600	PHYSICAL THERAPY	0	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99 07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00 08800	RURAL HEALTH CLINIC	0	88.00
90.00 09000	CLINIC	0	90.00
91.00 09100	EMERGENCY	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10 09910	CORF	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS			
192.01 19201	RETAIL PHARMACY	0	192.01
193.01 19301	MATTOON CLINIC	0	193.01
194.00 07950	FOUNDATION	0	194.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		
					Disallowance		Total Costs
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	6,557,480		6,557,480	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,000,133		3,000,133	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,969,796		3,969,796	0	0	54.00
60.00	06000 LABORATORY	2,985,403		2,985,403	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
66.00	06600 PHYSICAL THERAPY	1,020,530	0	1,020,530	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	145,111		145,111	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,053		56,053	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,287,527		1,287,527	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	37,964,321		37,964,321	0	0	88.00
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	4,181,918		4,181,918	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,827,643		2,827,643	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
200.00	Subtotal (see instructions)	63,995,915	0	63,995,915	0	0	200.00
201.00	Less Observation Beds	2,827,643		2,827,643	0	0	201.00
202.00	Total (see instructions)	61,168,272	0	61,168,272	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/29/2019 11:11 am	
			Title XVIII		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,522,917		2,522,917			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	132,642	1,501,400	1,634,042	1.836020	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,020	21,193,353	22,300,373	0.178015	0.000000	54.00
60.00	06000	LABORATORY	1,085,428	20,817,662	21,903,090	0.136301	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	154,695	1,490,122	1,644,817	0.620452	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	370,951	750,444	1,121,395	0.129402	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	137,839	46,459	184,298	0.304143	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	649,443	3,391,601	4,041,044	0.318612	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	52,807,047	52,807,047			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	550,270	13,777,446	14,327,716	0.291876	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	513,454	2,720,155	3,233,609	0.874454	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	7,224,659	118,495,689	125,720,348			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,224,659	118,495,689	125,720,348			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 11:11 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet C
Part I
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,557,480		6,557,480	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,000,133		3,000,133	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,969,796		3,969,796	0	0 54.00
60.00	06000 LABORATORY	2,985,403		2,985,403	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
66.00	06600 PHYSICAL THERAPY	1,020,530	0	1,020,530	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	145,111		145,111	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,053		56,053	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,287,527		1,287,527	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	37,964,321		37,964,321	0	0 88.00
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	4,181,918		4,181,918	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0	0	0 99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0 99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0 99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0 99.40
200.00	Subtotal (see instructions)	61,168,272	0	61,168,272	0	0 200.00
201.00	Less Observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	61,168,272	0	61,168,272	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Title XIX			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LI THOTRI PSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital Cost							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,250,856	1,634,042	0.765498	56,670	43,381	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	652,082	22,300,373	0.029241	599,930	17,543	54.00
60.00	06000 LABORATORY	353,595	21,903,090	0.016144	583,120	9,414	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	175,937	1,644,817	0.106964	24,869	2,660	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,171	1,121,395	0.001044	143,712	150	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	452	184,298	0.002453	69,750	171	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,522	4,041,044	0.005078	359,807	1,827	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,147,390	52,807,047	0.021728	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	903,320	14,327,716	0.063047	28,780	1,814	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,174,238	3,233,609	0.363135	245,454	89,133	92.00
200.00	Total (lines 50 through 199)	5,679,563	123,197,431		2,112,092	166,093	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	Title XVIII				Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Title XVIII			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,634,042	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,300,373	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	21,903,090	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	1,644,817	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,121,395	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	184,298	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,041,044	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	52,807,047	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	14,327,716	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,233,609	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	123,197,431		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Title XVIII			Hospital		Cost
		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	56,670	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	599,930	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	583,120	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.000000	24,869	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	143,712	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	69,750	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	359,807	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	28,780	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	245,454	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,112,092	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 11:11 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	1.836020	0	344,397	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.178015	0	5,204,520	0	0
60.00 06000 LABORATORY	0.136301	0	6,045,272	0	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.620452	0	358,640	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.129402	0	208,103	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.304143	0	10,055	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.318612	0	1,356,656	0	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.291876	0	6,568,612	345	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.874454	0	1,062,957	0	0
200.00 Subtotal (see instructions)		0	21,159,212	345	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 - line 201)		0	21,159,212	345	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 11:11 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	632,320	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	926,483	0	54.00
60.00	06000 LABORATORY	823,977	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00	06600 PHYSICAL THERAPY	222,519	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,929	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,058	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	432,247	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	1,917,220	101	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	929,507	0	92.00
200.00	Subtotal (see instructions)	5,914,260	101	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	5,914,260	101	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1316 Component CCN: 14-Z316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 11:11 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1.836020	0	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178015	0	0	0	0 54.00
60.00	06000 LABORATORY	0.136301	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
66.00	06600 PHYSICAL THERAPY	0.620452	0	0	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.129402	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.304143	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.318612	0	0	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
90.00	09000 CLINIC	0.000000	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.291876	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.874454	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1316 Component CCN: 14-Z316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 11:11 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
66.00 06600 PHYSICAL THERAPY	0	0		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/29/2019 11:11 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,723,134	0	2,723,134	1,567	1,737.80	30.00
200.00	Total (lines 30 through 199)	2,723,134		2,723,134	1,567		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	71	123,384				30.00
200.00	Total (lines 30 through 199)	71	123,384				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Title XIX			Hospital	Cost
		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,250,856	0	0.000000	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	652,082	0	0.000000	0	0 54.00
60.00	06000 LABORATORY	353,595	0	0.000000	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
66.00	06600 PHYSICAL THERAPY	175,937	0	0.000000	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,171	0	0.000000	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	452	0	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,522	0	0.000000	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,147,390	0	0.000000	0	0 88.00
90.00	09000 CLINIC	0	0	0.000000	0	0 90.00
91.00	09100 EMERGENCY	903,320	0	0.000000	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0 92.00
200.00	Total (lines 50 through 199)	4,505,325	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/29/2019 11:11 am		
Cost Center Description			Title XIX		Hospital		Cost		
			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	1,567	0.00	71	30.00	
200.00		Total (lines 30 through 199)		0	1,567		71	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	Title XIX				Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	Title XIX			Hospital	Cost		
	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	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description	Title XIX			Hospital		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	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	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0.000000	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
66.00 06600 PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
90.00 09000 CLINIC	0.000000	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 11:11 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,885 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,567 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)			816 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			170 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			148 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)			447 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)			170 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			117.40 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			117.40 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,557,480 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)			17,375 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)			657,454 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,900,026 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,900,026 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)			3,765.17 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,683,031 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)			1,683,031 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 11:11 am
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)					683,242 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,366,273 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					640,079 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)					640,079 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)					751 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,765.17 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,827,643 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 11:11 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,723,134	6,557,480	0.415271	2,827,643	1,174,238	90.00
91.00	Nursing School cost	0	6,557,480	0.000000	2,827,643	0	91.00
92.00	Allied health cost	0	6,557,480	0.000000	2,827,643	0	92.00
93.00	All other Medical Education	0	6,557,480	0.000000	2,827,643	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 11:11 am	
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		1,225,650		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.836020	56,670	104,047	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178015	599,930	106,797	54.00
60.00	06000 LABORATORY	0.136301	583,120	79,480	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.620452	24,869	15,430	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.129402	143,712	18,597	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.304143	69,750	21,214	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.318612	359,807	114,639	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.291876	28,780	8,400	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.874454	245,454	214,638	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,112,092	683,242	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,112,092		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1316 Component CCN: 14-Z316	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 11:11 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		158,670		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.836020	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178015	13,680	2,435	54.00
60.00	06000 LABORATORY	0.136301	29,372	4,003	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.620452	52,545	32,602	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.129402	10,432	1,350	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.304143	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.318612	40,895	13,030	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.291876	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.874454	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		146,924	53,420	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)		146,924		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 11:11 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,914,361	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)		5,914,361	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,973,505	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)		16,579	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,416,545	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)		3,540,381	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)		3,540,381	30.00
31.00	Primary payer payments		4,373	31.00
32.00	Subtotal (line 30 minus line 31)		3,536,008	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)		632,528	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		411,143	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		630,585	36.00
37.00	Subtotal (see instructions)		3,947,151	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,947,151	40.00
40.01	Sequestration adjustment (see instructions)		78,943	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,215,081	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		653,127	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1316		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 11:11 am	
		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		1,908,846		2,908,773	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		7,706		95,063	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	08/08/2018	94,357	08/08/2018	154,662		3.01
3.02		11/21/2018	17,050	11/21/2018	56,583		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)		111,407		211,245		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,027,959		3,215,081		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		200,115		653,127		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,228,074		3,868,208		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: 14-1316
Component CCN: 14-Z316

Period:
From 01/01/2018
To 12/31/2018

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2019 11:11 am

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		466,552		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/08/2018	42,794		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)		42,794		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)		509,346		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		176,915		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		686,261		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2019 11:11 am

		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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2
		Component CCN: 14-Z316		Date/Time Prepared: 5/29/2019 11:11 am
		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)	646,480	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)	53,954	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	170	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)	700,434	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	700,434	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	700,434	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	168	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	700,266	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	700,266	0	19.00
19.01	Sequestration adjustment (see instructions)	14,005	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	509,346	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	176,915	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison 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: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 11:11 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,366,273 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)			2,366,273 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,389,936 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)			2,389,936 19.00
20.00	Deductibles (exclude professional component)			138,180 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,251,756 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,251,756 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			33,522 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			21,789 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			33,522 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,273,545 28.00
29.00	LOSS ON SALE OF ASSETS			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,273,545 30.00
30.01	Sequestration adjustment (see instructions)			45,471 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			2,027,959 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)			200,115 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet G
Date/Time Prepared:
5/29/2019 11:11 am

		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	-451,126	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	16,618,883	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,499,143	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	136,960	0	0	0	8.00
9.00	Other current assets	1,145,278	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,950,852	0	0	0	11.00
FIXED ASSETS						
12.00	Land	104,595	0	0	0	12.00
13.00	Land improvements	1,107,068	0	0	0	13.00
14.00	Accumulated depreciation	-444,458	0	0	0	14.00
15.00	Buildings	11,594,188	0	0	0	15.00
16.00	Accumulated depreciation	-4,137,196	0	0	0	16.00
17.00	Leasehold improvements	1,735,646	0	0	0	17.00
18.00	Accumulated depreciation	-1,249,016	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	105,008	0	0	0	21.00
22.00	Accumulated depreciation	-55,042	0	0	0	22.00
23.00	Major movable equipment	10,550,788	0	0	0	23.00
24.00	Accumulated depreciation	-5,984,932	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	277,839	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,604,488	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,229,906	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	4,444,690	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,674,596	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,229,936	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	258,662	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,561,364	0	0	0	38.00
39.00	Payroll taxes payable	0	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	0	0	0	42.00
43.00	Due to other funds	15,473,460	0	0	0	43.00
44.00	Other current liabilities	5,906,341	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,199,827	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	8,212,394	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,212,394	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,412,221	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,182,285				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)	-3,182,285	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,229,936	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-1

Date/Time Prepared:
5/29/2019 11:11 am

		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		-6,580,549		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,573,127		0		2.00
3.00	Total (sum of line 1 and line 2)		-11,153,676				3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-11,153,676			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)		-11,153,676			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1316

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2019 11:11 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,355,737		2,355,737	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,355,737		2,355,737	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)	2,355,737		2,355,737	17.00
18.00	Ancillary services	4,941,501	77,231,210	82,172,711	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	50,226,687	50,226,687	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
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,297,238	127,457,897	134,755,135	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,272,687		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	INCOME TAXES	5,000			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)		5,000		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)		62,277,687		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 11:11 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	134,755,135	1.00
2.00	Less contractual allowances and discounts on patients' accounts	77,525,185	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,229,950	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,277,687	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,047,737	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	55,872	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	158	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRUST INCOME	0	24.00
24.01	MI SCCELLANEOUS INCOME	13,872	24.01
24.02	PATIENT BILLING	15,990	24.02
24.03	GRANTS	196,375	24.03
24.04	RESTRICTED REVENUE	11,000	24.04
24.05	UNRESTRICTED REVENUE	164,050	24.05
24.06	BOND PROCEED INCOME	15,002	24.06
24.07	OTHER	2,291	24.07
25.00	Total other income (sum of lines 6-24)	474,610	25.00
26.00	Total (line 5 plus line 25)	-4,573,127	26.00
27.00	LOSS ON DISPOSAL	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)	-4,573,127	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1316 Component CCN: 14-3448		Period: From 01/01/2018 To 12/31/2018		Worksheet M-1 Date/Time Prepared: 5/29/2019 11:11 am	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	11,936,278	11,936,278	0	11,936,278	1.00
2.00	Physician Assistant	1,177,669	0	1,177,669	0	1,177,669	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	5,349,851	0	5,349,851	0	5,349,851	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	38,083	0	38,083	0	38,083	8.00
9.00	Other Facility Health Care Staff Costs	2,082,855	0	2,082,855	0	2,082,855	9.00
10.00	Subtotal (sum of lines 1 through 9)	8,648,458	11,936,278	20,584,736	0	20,584,736	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	2,168,621	2,168,621	0	2,168,621	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,168,621	2,168,621	0	2,168,621	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	8,648,458	14,104,899	22,753,357	0	22,753,357	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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	1,644,022	6,517,153	8,161,175	-1,982,907	6,178,268	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,644,022	6,517,153	8,161,175	-1,982,907	6,178,268	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	10,292,480	20,622,052	30,914,532	-1,982,907	28,931,625	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1316 Component CCN: 14-3448		Period: From 01/01/2018 To 12/31/2018	Worksheet M-1 Date/Time Prepared: 5/29/2019 11:11 am
		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	11,936,278		1.00
2.00	Physician Assistant	0	1,177,669		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	5,349,851		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	38,083		8.00
9.00	Other Facility Health Care Staff Costs	0	2,082,855		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	20,584,736		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	2,168,621		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,168,621		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	22,753,357		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	79,503	6,257,771		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,503	6,257,771		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	79,503	29,011,128		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2018 To 12/31/2018	Worksheet M-2 Date/Time Prepared: 5/29/2019 11:11 am
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	24.70	101,854	4,200	103,740	1.00
2.00	Physician Assistant	9.75	74,826	2,100	20,475	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	34.45	176,680		124,215	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	34.45	176,680			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)				22,753,357	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)				22,753,357	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)				6,257,771	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				8,953,193	15.00
16.00	Total overhead (sum of lines 14 and 15)				15,210,964	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				15,210,964	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				15,210,964	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				37,964,321	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 11:11 am
		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)		37,964,321	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,771,610	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		36,192,711	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		176,680	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)		176,680	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		204.85	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	204.85	204.85	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	32,820	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	6,723,177	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	6,723,177	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		4,935,130	16.04
16.05	Total program cost (see instructions)	0	4,935,130	16.05
17.00	Primary payer amounts		3,212	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		554,265	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,383,062	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		4,931,918	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		468,454	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		5,400,372	22.00
23.00	Allowable bad debts (see instructions)		222,232	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		144,451	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		222,148	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)		5,544,823	26.00
26.01	Sequestration adjustment (see instructions)		110,896	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		4,460,297	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)		973,630	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 11:11 am	
		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)		20,584,736	20,584,736	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.006132	0.017092	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		126,226	351,834	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		387,781	195,949	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		514,007	547,783	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		22,753,357	22,753,357	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		15,210,964	15,210,964	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.022590	0.024075	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		343,616	366,204	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		857,623	913,987	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		2,520	8,139	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		340.33	112.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		768	1,844	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		261,373	207,081	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)			1,771,610	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)			468,454	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 11:11 am
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		4,431,337	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		08/08/2018	28,960	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		28,960	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		4,460,297	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		973,630	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		5,433,927	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00