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: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/8/2019 8:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/8/2019 Time: 8:37 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PANA COMMUNITY HOSPITAL (14-1341) 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.

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

(Signed) JAMES MOON
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	54,504	251,630	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	55,586	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RHCS (CONSOLIDATED) I	0		74,843		0	10.00
200.00	Total	0	110,090	326,473	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2019 8:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 101 E. 9TH STREET	PO Box:			1.00
2.00	City: PANA	State: IL	Zip Code: 62557-1716	County: CHRISTIAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PANA COMMUNITY HOSPITAL	141341	99914	1	11/01/2004	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PANA COMMUNITY HOSPITAL	14Z341	99914		04/06/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	QUAD COUNTY HOME HEALTH AGENCY	147299	99914		01/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	PCH HOSPICE	141575	99914		08/31/1994				14.00
15.00	Hospital-Based Health Clinic - RHC	COMMUNITY MEDICAL CLINIC PANA	148508	99914		03/18/2010	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			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.	3	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2019 8:37 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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/8/2019 8:37 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/8/2019 8:37 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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/8/2019 8:37 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/8/2019 8:37 am

		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:	96,793	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2019 8:37 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2017	12/31/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/8/2019 8:37 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	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/29/2019	Y	03/29/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/8/2019 8:37 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		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/8/2019 8:37 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/8/2019 8:37 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	30,792.00	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	30,792.00	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	30,792.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/8/2019 8:37 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	903	45	1,283			1.00
2.00	HMO and other (see instructions)	121	53				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	308	0	344			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,211	45	1,642			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,211	45	1,642	0.00	144.33	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	5,552	0	8,184	0.00	14.88	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	7.59	24.00
24.10	HOSPICE (non-distinct part)			20			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	3,396	0	13,617	0.00	21.77	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	188.57	27.00
28.00	Observation Bed Days		0	44			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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/8/2019 8:37 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	283	18	404	1.00
2.00	HMO and other (see instructions)			45	16		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	283	18	404	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 5/8/2019 8:37 am

Home Health Agency I | PPS

					1.00		
0.00	County				CHRISTIAN		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	60	8	10	78	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	391.00	50.00	67.00	508.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.15	0.00	1.15	4.00
5.00	Other Administrative Personnel			1.98	0.00	1.98	5.00
6.00	Direct Nursing Service			7.08	0.00	7.08	6.00
7.00	Nursing Supervisor			0.59	0.00	0.59	7.00
8.00	Physical Therapy Service			1.94	0.00	1.94	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.44	0.00	0.44	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.06	0.00	0.06	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.06	0.00	0.06	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.04	0.00	0.04	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	DME			1.54	0.00	1.54	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,954	153	80	14	2,201	21.00
22.00	Skilled Nursing Visit Charges	364,176	28,064	15,219	2,581	410,040	22.00
23.00	Physical Therapy Visits	2,468	3	21	34	2,526	23.00
24.00	Physical Therapy Visit Charges	504,759	615	4,274	6,886	516,534	24.00
25.00	Occupational Therapy Visits	645	3	1	6	655	25.00
26.00	Occupational Therapy Visit Charges	141,680	650	220	1,320	143,870	26.00
27.00	Speech Pathology Visits	46	1	1	0	48	27.00
28.00	Speech Pathology Visit Charges	10,120	220	220	0	10,560	28.00
29.00	Medical Social Service Visits	32	4	1	1	38	29.00
30.00	Medical Social Service Visit Charges	8,103	1,016	254	254	9,627	30.00
31.00	Home Health Aide Visits	83	0	1	0	84	31.00
32.00	Home Health Aide Visit Charges	10,209	0	123	0	10,332	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,228	164	105	55	5,552	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,039,047	30,565	20,310	11,041	1,100,963	35.00
36.00	Total Number of Episodes (standard/non outlier)	352		35	5	392	36.00
37.00	Total Number of Outlier Episodes		7		0	7	37.00
38.00	Total Non-Routine Medical Supply Charges	6,155	1,593	366	0	8,114	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/8/2019 8:37 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	101 E. 9TH STREET, SUITE 105	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PANA	IL	62557	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	20:00	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	3	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number	COMMUNITY MEDICAL CLINIC PANA	148508	14.00
14.01		COMMUNITY MEDICAL CLINIC OF ASSUMPTI	148575	14.01
14.02		COMMUNITY MEDICAL CLINIC OF NOKOMIS	148574	14.02

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	CHRISTIAN	2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1341
Component CCN: 14-8508

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

Worksheet S-8
Date/Time Prepared:
5/8/2019 8:37 am

RHC I | Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	20:00	08:30	20:00	08:30	20:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	6,672	728	955	8,355	11.00
12.00	Hospice Inpatient Respite Care	12	0	1	13	12.00
13.00	Hospice General Inpatient Care	7	0	0	7	13.00
14.00	Total Hospice Days	6,691	728	956	8,375	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/8/2019 8:37 am

		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)	0.388970	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,056,263	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,245,565	5.00
6.00	Medicaid charges	9,995,861	6.00
7.00	Medicaid cost (line 1 times line 6)	3,888,090	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,944	21,169	30,113	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,479	21,169	24,648	21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,472	10,584	15,056	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	10,585	10,585	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)	1,872,226	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	334,195	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	514,146	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,358,080	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	708,203	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	718,788	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	718,788	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		587,028	587,028	24,980	612,008	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		341,784	341,784	15,738	357,522	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,960,990	2,960,990	-16,597	2,944,393	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	124,571	124,571	5.01
5.02	00550	DATA PROCESSING	322,211	218,983	541,194	-92,591	448,603	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	371,552	298,944	670,496	-30,676	639,820	5.03
5.04	00590	OTHER ADMIN AND GENERAL	753,661	1,098,216	1,851,877	76,400	1,928,277	5.04
7.00	00700	OPERATION OF PLANT	233,262	430,365	663,627	41	663,668	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,627	68,627	8.00
9.00	00900	HOUSEKEEPING	215,839	97,541	313,380	-68,627	244,753	9.00
10.00	01000	DIETARY	181,023	162,838	343,861	-270,960	72,901	10.00
11.00	01100	CAFETERIA	0	0	0	77,072	77,072	11.00
13.00	01300	NURSING ADMINISTRATION	307,067	4,113	311,180	0	311,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,816	38,570	71,386	0	71,386	14.00
15.00	01500	PHARMACY	209,603	1,363,116	1,572,719	-1,249,705	323,014	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,633	92,437	246,070	0	246,070	16.00
17.00	01700	SOCIAL SERVICE	45,935	1,299	47,234	0	47,234	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	216,948	0	216,948	16,597	233,545	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	907,000	188,072	1,095,072	0	1,095,072	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	454,903	415,068	869,971	0	869,971	50.00
53.00	05300	ANESTHESIOLOGY	0	12,196	12,196	0	12,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	493,725	890,843	1,384,568	0	1,384,568	54.00
60.00	06000	LABORATORY	569,793	458,972	1,028,765	0	1,028,765	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	486,172	156,905	643,077	0	643,077	65.00
66.00	06600	PHYSICAL THERAPY	577,991	30,813	608,804	0	608,804	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,397	7,397	0	7,397	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,191,972	1,191,972	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	1,768,660	440,025	2,208,685	2,553	2,211,238	88.00
91.00	09100	EMERGENCY	810,114	1,811,935	2,622,049	0	2,622,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	723,594	301,613	1,025,207	-3,877	1,021,330	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	400,217	265,032	665,249	-5,804	659,445	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,235,719	12,675,095	22,910,814	-140,286	22,770,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,240,054	228,169	1,468,223	-2,286	1,465,937	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	84,839	84,839	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	91,315	36,956	128,271	0	128,271	194.01
194.02	07952	FOUNDATION	47,122	2,233	49,355	0	49,355	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	57,733	57,733	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	11,614,210	12,942,453	24,556,663	0	24,556,663	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/8/2019 8:37 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	0	612,008		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,722	352,800		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-389,646	2,554,747		4.00
5.01	00540	NONPATIENT TELEPHONES	-7,978	116,593		5.01
5.02	00550	DATA PROCESSING	0	448,603		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	639,820		5.03
5.04	00590	OTHER ADMIN AND GENERAL	-501,505	1,426,772		5.04
7.00	00700	OPERATION OF PLANT	-7,985	655,683		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,627		8.00
9.00	00900	HOUSEKEEPING	0	244,753		9.00
10.00	01000	DIETARY	-6,806	66,095		10.00
11.00	01100	CAFETERIA	-16,039	61,033		11.00
13.00	01300	NURSING ADMINISTRATION	0	311,180		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,386		14.00
15.00	01500	PHARMACY	0	323,014		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-37,105	208,965		16.00
17.00	01700	SOCIAL SERVICE	0	47,234		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	233,545		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-257,217	837,855		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-353,204	516,767		50.00
53.00	05300	ANESTHESIOLOGY	0	12,196		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,384,568		54.00
60.00	06000	LABORATORY	-1,045	1,027,720		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-61,640	581,437		65.00
66.00	06600	PHYSICAL THERAPY	0	608,804		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,397		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,191,972		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHCS (CONSOLIDATED)	-8,084	2,203,154		88.00
91.00	09100	EMERGENCY	-876,919	1,745,130		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,021,330		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	20,384	679,829		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,509,511	20,261,017		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,465,937		192.00
194.00	07950	HOMEBOUND MEALS	0	84,839		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	128,271		194.01
194.02	07952	FOUNDATION	0	49,355		194.02
194.03	07953	RETAIL 340B PHARMACY	0	57,733		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,509,511	22,047,152		200.00

RECLASSIFICATIONS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/8/2019 8:37 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY COSTS				
1.00	CAFETERIA	11.00	40,574	36,498	1.00
2.00	OTHER ADMIN AND GENERAL	5.04	57,408	51,641	2.00
3.00	HOMEBOUND MEALS	194.00	44,663	40,176	3.00
	0		142,645	128,315	
	B - CRNAS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	16,597	1.00
	0		0	16,597	
	C - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	40,718	1.00
	0		0	40,718	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,627	1.00
	0		0	68,627	
	E - TELEPHONE AND POSTAGE				
1.00	NONPATIENT TELEPHONES	5.01	31,980	92,591	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	1,304	2.00
3.00		0.00	0	0	3.00
	0		31,980	93,895	
	F - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	41	1.00
	0		0	41	
	G - RHC PHYSICIAN RECRUITMENT				
1.00	RHCS (CONSOLIDATED)	88.00	0	3,061	1.00
	0		0	3,061	
	H - ADVERTISING				
1.00	OTHER ADMIN AND GENERAL	5.04	0	11,130	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	11,130	
	J - RETAIL 340B PHARMACY				
1.00	RETAIL 340B PHARMACY	194.03	0	57,733	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,191,972	2.00
	0		0	1,249,705	
500.00	Grand Total: Increases		174,625	1,612,089	500.00

RECLASSIFICATIONS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/8/2019 8:37 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY COSTS						
1.00	DIETARY	10.00	142,645	128,315	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		142,645	128,315			
	B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16,597	0		1.00
	0		0	16,597			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.04	0	40,718	12		1.00
	0		0	40,718			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	68,627	0		1.00
	0		0	68,627			
	E - TELEPHONE AND POSTAGE						
1.00	DATA PROCESSING	5.02		92,591	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	31,980		0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00		1,304	0		3.00
	0		31,980	93,895			
	F - UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	41	0		1.00
	0		0	41			
	G - RHC PHYSICIAN RECRUITMENT						
1.00	OTHER ADMIN AND GENERAL	5.04	0	3,061	0		1.00
	0		0	3,061			
	H - ADVERTISING						
1.00	RHCS (CONSOLIDATED)	88.00	0	508	0		1.00
2.00	HOME HEALTH AGENCY	101.00	0	3,877	0		2.00
3.00	HOSPICE	116.00	0	5,804	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	941	0		4.00
	0		0	11,130			
	J - RETAIL 340B PHARMACY						
1.00	PHARMACY	15.00	0	1,249,705	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,249,705			
500.00	Grand Total: Decreases		174,625	1,612,089			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/8/2019 8:37 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	51,361	0	0	0	0	1.00
2.00	Land Improvements	778,726	85,800	0	85,800	0	2.00
3.00	Buildings and Fixtures	11,162,760	67,951	0	67,951	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	599,547	0	0	0	0	5.00
6.00	Movable Equipment	7,758,347	295,554	0	295,554	23,524	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,350,741	449,305	0	449,305	23,524	8.00
9.00	Reconciling Items	-3,791,595	-13,300,871	0	-13,300,871	0	9.00
10.00	Total (line 8 minus line 9)	24,142,336	13,750,176	0	13,750,176	23,524	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	51,361	0	1.00
2.00	Land Improvements	864,526	0	2.00
3.00	Buildings and Fixtures	11,230,711	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	599,547	0	5.00
6.00	Movable Equipment	8,030,377	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,776,522	0	8.00
9.00	Reconciling Items	-17,092,466	0	9.00
10.00	Total (line 8 minus line 9)	37,868,988	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/8/2019 8:37 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	587,028	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	341,784	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	928,812	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	587,028		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	341,784		2.00
3.00	Total (sum of lines 1-2)	0	928,812		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/8/2019 8:37 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,746,145	0	12,746,145	0.613488	24,980	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,030,377	0	8,030,377	0.386512	15,738	2.00
3.00	Total (sum of lines 1-2)	20,776,522	0	20,776,522	1.000000	40,718	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	24,980	587,028	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	15,738	337,062	0	2.00
3.00	Total (sum of lines 1-2)	0	0	40,718	924,090	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	24,980	0	0	612,008	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,738	0	0	352,800	2.00
3.00	Total (sum of lines 1-2)	0	40,718	0	0	964,808	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/8/2019 8:37 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	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,529,641			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-16,039	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-37,105	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-6,806	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-20,384	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-4,624	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	ADVERTISING	A	-64,238	OTHER ADMIN AND GENERAL	5.04	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/8/2019 8:37 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	5.00	
34.00	PHYSICIAN RECRUITMENT	A	-3,142	OTHER ADMIN AND GENERAL	5.04	0	34.00
35.00	WAGE GARNISHMENT FEE	B	-29	OTHER ADMIN AND GENERAL	5.04	0	35.00
36.00	PATIENT PHONE COSTS	A	-98	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01	PATIENT PHONE COSTS	A	-538	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02	PATIENT PHONE COSTS - SALARY	A	-2,364	NONPATIENT TELEPHONES	5.01	0	36.02
36.03	PATIENT PHONE COSTS - OTHER	A	-5,614	NONPATIENT TELEPHONES	5.01	0	36.03
38.00	SELF-INS CASH PMNTS TO HOSPITAL	A	-318,172	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MISC OTHER OPERATING REVENUE	B	-4,932	OTHER ADMIN AND GENERAL	5.04	0	39.00
40.00	HOSPICE COSTS	A	20,384	HOSPICE	116.00	0	40.00
41.00	LOBBYING	A	-9,799	OTHER ADMIN AND GENERAL	5.04	0	41.00
44.00	MEDICAID TAX	A	-408,285	OTHER ADMIN AND GENERAL	5.04	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01	RHC NON-ALLOWABLE SALARIES	A	-8,084	RHCS (CONSOLIDATED)	88.00	0	45.01
45.02	RHC NON-ALLOWABLE BENEFITS	A	-420	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	PHYSICIAN BENEFITS	A	-70,516	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	CABLE TV	A	-7,985	OPERATION OF PLANT	7.00	0	45.04
45.05	GOODWILL AMORTIZATION	A	-11,080	OTHER ADMIN AND GENERAL	5.04	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,509,511				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/8/2019 8:37 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	60.00	LABORATORY	16,563	1,045	15,518	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	61,640	61,640	0	0	0	2.00
3.00	91.00	EMERGENCY	1,659,790	837,305	822,485	0	0	3.00
4.00	91.00	EMERGENCY	39,614	39,614	0	0	0	4.00
5.00	50.00	OPERATING ROOM	353,204	353,204	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	236,833	236,833	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,367,644	1,529,641	838,003		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	1,045		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	61,640		2.00
3.00	91.00	EMERGENCY	0	0	0	837,305		3.00
4.00	91.00	EMERGENCY	0	0	0	39,614		4.00
5.00	50.00	OPERATING ROOM	0	0	0	353,204		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	236,833		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,529,641		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/8/2019 8:37 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					9	1.00
2.00	Line 1 multiplied by 15 hours per week					135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					9	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.54	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	72.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.97	36.97	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,324	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					5,324	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					5,324	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					9,982	22.00
23.00	Total salary equivalency (see instructions)					9,982	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					333	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					333	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					5	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					338	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					338	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/8/2019 8:37 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	9,982		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	338		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	10,320		63.00
64.00	Total cost of outside supplier services (from your records)	5,550		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	333		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	5		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	338		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	5		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	5		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	612,008	612,008				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	352,800		352,800			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,554,747	0	0	2,554,747		4.00
5.01	00540	NONPATIENT TELEPHONES	116,593	384	1,283	6,907	125,167	5.01
5.02	00550	DATA PROCESSING	448,603	9,522	7,175	75,150	13,104	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	639,820	11,449	635	79,199	7,682	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,426,772	42,923	4,213	189,167	6,326	5.04
7.00	00700	OPERATION OF PLANT	655,683	147,406	4,286	54,404	1,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,627	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	244,753	8,335	0	50,341	452	9.00
10.00	01000	DIETARY	66,095	13,452	6,755	8,951	1,807	10.00
11.00	01100	CAFETERIA	61,033	3,087	0	9,463	0	11.00
13.00	01300	NURSING ADMINISTRATION	311,180	4,082	0	71,618	1,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,386	5,042	0	7,654	452	14.00
15.00	01500	PHARMACY	323,014	5,220	3,428	48,886	1,807	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,965	4,130	554	35,832	7,230	16.00
17.00	01700	SOCIAL SERVICE	47,234	1,118	0	10,714	452	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	233,545	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	837,855	52,965	6,120	156,304	13,555	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	516,767	24,682	83,913	60,314	5,422	50.00
53.00	05300	ANESTHESIOLOGY	12,196	0	10,933	0	452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,384,568	24,168	127,510	115,152	6,778	54.00
60.00	06000	LABORATORY	1,027,720	7,079	35,791	132,894	2,711	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	581,437	22,864	26,407	113,391	4,067	65.00
66.00	06600	PHYSICAL THERAPY	608,804	53,555	12,487	134,806	6,326	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,397	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,191,972	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	2,203,154	39,712	4,140	410,622	10,393	88.00
91.00	09100	EMERGENCY	1,745,130	22,706	12,550	188,945	10,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,021,330	22,501	2,638	168,765	6,778	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	679,829	0	0	93,343	904	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,261,017	526,382	350,818	2,222,822	110,255	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,537	0	0	904	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,465,937	72,091	991	289,220	13,104	192.00
194.00	07950	HOMEBOUND MEALS	84,839	0	0	10,417	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	128,271	10,626	0	21,298	452	194.01
194.02	07952	FOUNDATION	49,355	1,372	991	10,990	452	194.02
194.03	07953	RETAIL 340B PHARMACY	57,733	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,047,152	612,008	352,800	2,554,747	125,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.04	7.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	553,554					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	46,685	785,470				5.03
5.04	00590	OTHER ADMIN AND GENERAL	30,012	0	1,699,413	1,699,413		5.04
7.00	00700	OPERATION OF PLANT	3,335	0	866,470	72,367	938,837	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	68,627	5,732	0	8.00
9.00	00900	HOUSEKEEPING	3,335	0	307,216	25,658	19,547	9.00
10.00	01000	DIETARY	13,339	0	110,399	9,220	31,548	10.00
11.00	01100	CAFETERIA	0	0	73,583	6,146	7,240	11.00
13.00	01300	NURSING ADMINISTRATION	10,004	0	398,240	33,261	9,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,335	0	87,869	7,339	11,825	14.00
15.00	01500	PHARMACY	6,669	0	389,024	32,491	12,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,343	0	280,054	23,390	9,685	16.00
17.00	01700	SOCIAL SERVICE	3,335	0	62,853	5,249	2,622	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	233,545	19,505	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,343	37,790	1,127,932	94,204	124,214	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,673	46,287	754,058	62,978	57,884	50.00
53.00	05300	ANESTHESIOLOGY	0	12,351	35,932	3,001	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,016	244,760	1,942,952	162,273	56,677	54.00
60.00	06000	LABORATORY	30,012	172,378	1,408,585	117,644	16,603	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,008	58,842	827,016	69,072	53,621	65.00
66.00	06600	PHYSICAL THERAPY	43,351	47,173	906,502	75,710	125,598	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,851	10,248	856	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	80,424	1,272,396	106,269	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	63,359	0	2,731,380	228,110	93,132	88.00
91.00	09100	EMERGENCY	40,016	82,614	2,102,806	175,624	53,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	36,681	0	1,258,693	105,125	52,768	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	6,669	0	780,745	65,207	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	463,520	785,470	19,736,538	1,506,431	738,030	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	2,441	204	3,604	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,695	0	1,918,038	160,193	169,065	192.00
194.00	07950	HOMEBOUND MEALS	0	0	95,256	7,956	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	10,004	0	170,651	14,253	24,920	194.01
194.02	07952	FOUNDATION	3,335	0	66,495	5,554	3,218	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	57,733	4,822	0	194.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	553,554	785,470	22,047,152	1,699,413	938,837	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,359					8.00
9.00	00900	HOUSEKEEPING	0	352,421				9.00
10.00	01000	DIETARY	0	14,215	165,382			10.00
11.00	01100	CAFETERIA	0	3,262	0	90,231		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,313	0	2,318	447,704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,328	0	819	0	14.00
15.00	01500	PHARMACY	0	5,516	0	1,808	15,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,364	0	2,341	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,182	0	750	6,365	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	641	5,444	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,372	55,969	165,382	9,464	80,371	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,606	26,082	0	3,175	26,965	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,198	25,538	0	6,559	55,700	54.00
60.00	06000	LABORATORY	0	7,481	0	7,610	64,623	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	285	24,161	0	6,760	57,406	65.00
66.00	06600	PHYSICAL THERAPY	12,124	56,592	0	6,621	56,227	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	29,162	0	12,617	0	88.00
91.00	09100	EMERGENCY	22,774	23,994	0	9,333	79,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	23,776	0	888	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	773	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,359	310,935	165,382	72,477	447,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,624	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,183	0	15,011	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	11,229	0	1,955	0	194.01
194.02	07952	FOUNDATION	0	1,450	0	788	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,359	352,421	165,382	90,231	447,704	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,180					14.00
15.00	01500	PHARMACY	404	456,837				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	437	0	320,271			16.00
17.00	01700	SOCIAL SERVICE	17	0	0	79,038		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	259,135	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,825	0	14,499	63,230	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,322	0	17,760	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1,139	0	4,739	0	259,135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,055	0	93,922	0	0	54.00
60.00	06000	LABORATORY	26,688	0	66,139	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,774	0	22,577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,580	0	18,100	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,414	0	1,094	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	456,837	30,858	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	5,444	0	0	0	0	88.00
91.00	09100	EMERGENCY	13,109	0	31,698	15,808	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,042	0	10,858	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	288	0	8,027	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,538	456,837	320,271	79,038	259,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,296	0	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	330	0	0	0	0	194.01
194.02	07952	FOUNDATION	16	0	0	0	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	113,180	456,837	320,271	79,038	259,135	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,770,462	-71,739	1,698,723		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	973,830	1,735	975,565		50.00
53.00	05300	ANESTHESIOLOGY	303,946	0	303,946		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,362,874	0	2,362,874		54.00
60.00	06000	LABORATORY	1,715,373	0	1,715,373		60.00
64.00	06400	INTRAVENOUS THERAPY	0	70,004	70,004		64.00
65.00	06500	RESPIRATORY THERAPY	1,067,672	0	1,067,672		65.00
66.00	06600	PHYSICAL THERAPY	1,259,054	0	1,259,054		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,612	0	17,612		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,360	0	1,866,360		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHCS (CONSOLIDATED)	3,099,845	0	3,099,845		88.00
91.00	09100	EMERGENCY	2,527,649	0	2,527,649		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,459,150	0	1,459,150		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	855,040	0	855,040		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,278,867	0	19,278,867		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,873	0	7,873		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,293,786	0	2,293,786		192.00
194.00	07950	HOMEBOUND MEALS	103,212	0	103,212		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	223,338	0	223,338		194.01
194.02	07952	FOUNDATION	77,521	0	77,521		194.02
194.03	07953	RETAIL 340B PHARMACY	62,555	0	62,555		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	22,047,152	0	22,047,152		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	384	1,283	1,667	0	5.01
5.02	00550	DATA PROCESSING	0	9,522	7,175	16,697	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,236	11,449	635	13,320	0	5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	42,923	4,213	47,136	0	5.04
7.00	00700	OPERATION OF PLANT	0	147,406	4,286	151,692	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,335	0	8,335	0	9.00
10.00	01000	DIETARY	0	13,452	6,755	20,207	0	10.00
11.00	01100	CAFETERIA	0	3,087	0	3,087	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,082	0	4,082	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,042	0	5,042	0	14.00
15.00	01500	PHARMACY	0	5,220	3,428	8,648	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,130	554	4,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,118	0	1,118	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	52,965	6,120	59,085	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,707	24,682	83,913	162,302	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	10,933	10,933	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,168	127,510	151,678	0	54.00
60.00	06000	LABORATORY	0	7,079	35,791	42,870	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,374	22,864	26,407	55,645	0	65.00
66.00	06600	PHYSICAL THERAPY	0	53,555	12,487	66,042	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,666	0	0	17,666	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	9,900	39,712	4,140	53,752	0	88.00
91.00	09100	EMERGENCY	0	22,706	12,550	35,256	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	22,501	2,638	25,139	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,883	526,382	350,818	966,083	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,537	0	1,537	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,382	72,091	991	74,464	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	10,626	0	10,626	0	194.01
194.02	07952	FOUNDATION	0	1,372	991	2,363	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
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)	90,265	612,008	352,800	1,055,073	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.04	7.00	
		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
5.01	00540	NONPATIENT TELEPHONES	1,667					5.01
5.02	00550	DATA PROCESSING	175	16,872				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	102	1,423	14,845			5.03
5.04	00590	OTHER ADMIN AND GENERAL	84	915	0	48,135		5.04
7.00	00700	OPERATION OF PLANT	18	102	0	2,050	153,862	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	162	0	8.00
9.00	00900	HOUSEKEEPING	6	102	0	727	3,203	9.00
10.00	01000	DIETARY	24	407	0	261	5,170	10.00
11.00	01100	CAFETERIA	0	0	0	174	1,186	11.00
13.00	01300	NURSING ADMINISTRATION	18	305	0	942	1,569	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6	102	0	208	1,938	14.00
15.00	01500	PHARMACY	24	203	0	920	2,006	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96	711	0	663	1,587	16.00
17.00	01700	SOCIAL SERVICE	6	102	0	149	430	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	553	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183	711	714	2,669	20,357	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72	508	874	1,784	9,486	50.00
53.00	05300	ANESTHESIOLOGY	6	0	233	85	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90	1,220	4,634	4,597	9,289	54.00
60.00	06000	LABORATORY	36	915	3,255	3,333	2,721	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	54	610	1,111	1,957	8,788	65.00
66.00	06600	PHYSICAL THERAPY	84	1,321	891	2,145	20,584	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	54	24	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,519	3,010	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	138	1,931	0	6,455	15,263	88.00
91.00	09100	EMERGENCY	144	1,220	1,560	4,975	8,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	90	1,118	0	2,978	8,648	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	12	203	0	1,847	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,468	14,129	14,845	42,668	120,952	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	12	0	0	6	591	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	175	2,336	0	4,538	27,708	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	225	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	6	305	0	404	4,084	194.01
194.02	07952	FOUNDATION	6	102	0	157	527	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	137	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,667	16,872	14,845	48,135	153,862	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	162					8.00
9.00	00900	HOUSEKEEPING	0	12,373				9.00
10.00	01000	DIETARY	0	499	26,568			10.00
11.00	01100	CAFETERIA	0	115	0	4,562		11.00
13.00	01300	NURSING ADMINISTRATION	0	151	0	117	7,184	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	187	0	41	0	14.00
15.00	01500	PHARMACY	0	194	0	91	246	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	153	0	118	0	16.00
17.00	01700	SOCIAL SERVICE	0	41	0	38	102	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	32	87	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61	1,965	26,568	479	1,290	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8	916	0	161	433	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16	897	0	332	894	54.00
60.00	06000	LABORATORY	0	263	0	385	1,037	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1	848	0	342	921	65.00
66.00	06600	PHYSICAL THERAPY	26	1,987	0	335	902	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	1,024	0	638	0	88.00
91.00	09100	EMERGENCY	50	842	0	472	1,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	835	0	45	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	39	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162	10,917	26,568	3,665	7,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	57	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	954	0	758	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	394	0	99	0	194.01
194.02	07952	FOUNDATION	0	51	0	40	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	162	12,373	26,568	4,562	7,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,524					14.00
15.00	01500	PHARMACY	27	12,359				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29	0	8,041			16.00
17.00	01700	SOCIAL SERVICE	1	0	0	1,987		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	672	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	454	0	363	1,590		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,417	0	445	0		50.00
53.00	05300	ANESTHESIOLOGY	76	0	119	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801	0	2,370	0		54.00
60.00	06000	LABORATORY	1,775	0	1,657	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	450	0	566	0		65.00
66.00	06600	PHYSICAL THERAPY	105	0	454	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	360	0	27	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,359	773	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	362	0	0	0		88.00
91.00	09100	EMERGENCY	871	0	794	397		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	468	0	272	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	19	0	201	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,215	12,359	8,041	1,987	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	286	0	0	0		192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	22	0	0	0		194.01
194.02	07952	FOUNDATION	1	0	0	0		194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0		194.03
200.00		Cross Foot Adjustments					672	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,524	12,359	8,041	1,987	672	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	116,489	0	116,489		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	178,406	0	178,406		50.00
53.00	05300	ANESTHESIOLOGY	11,452	0	11,452		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,818	0	176,818		54.00
60.00	06000	LABORATORY	58,247	0	58,247		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	71,293	0	71,293		65.00
66.00	06600	PHYSICAL THERAPY	94,876	0	94,876		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	465	0	465		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,327	0	35,327		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHCS (CONSOLIDATED)	79,563	0	79,563		88.00
91.00	09100	EMERGENCY	56,580	0	56,580		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	39,593	0	39,593		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	2,321	0	2,321		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	921,430	0	921,430		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,203	0	2,203		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,219	0	111,219		192.00
194.00	07950	HOMEBOUND MEALS	225	0	225		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	15,940	0	15,940		194.01
194.02	07952	FOUNDATION	3,247	0	3,247		194.02
194.03	07953	RETAIL 340B PHARMACY	137	0	137		194.03
200.00		Cross Foot Adjustments	672	0	672		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,055,073	0	1,055,073		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,215					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		337,062				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,953,678			4.00
5.01	00540	NONPATIENT TELEPHONES	56	1,226	29,616	277		5.01
5.02	00550	DATA PROCESSING	1,388	6,855	322,211	29	166	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,669	607	339,572	17	14	5.03
5.04	00590	OTHER ADMIN AND GENERAL	6,257	4,025	811,069	14	9	5.04
7.00	00700	OPERATION OF PLANT	21,488	4,095	233,262	3	1	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,215	0	215,839	1	1	9.00
10.00	01000	DIETARY	1,961	6,454	38,378	4	4	10.00
11.00	01100	CAFETERIA	450	0	40,574	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	595	0	307,067	3	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	0	32,816	1	1	14.00
15.00	01500	PHARMACY	761	3,275	209,603	4	2	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602	529	153,633	16	7	16.00
17.00	01700	SOCIAL SERVICE	163	0	45,935	1	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,721	5,847	670,167	30	7	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,598	80,170	258,600	12	5	50.00
53.00	05300	ANESTHESIOLOGY	0	10,445	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523	121,822	493,725	15	12	54.00
60.00	06000	LABORATORY	1,032	34,194	569,793	6	9	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,333	25,229	486,172	9	6	65.00
66.00	06600	PHYSICAL THERAPY	7,807	11,930	577,991	14	13	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	5,789	3,955	1,760,576	23	19	88.00
91.00	09100	EMERGENCY	3,310	11,990	810,114	24	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,280	2,520	723,594	15	11	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	400,217	2	2	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,733	335,168	9,530,524	244	139	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	224	0	0	2	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,509	947	1,240,054	29	23	192.00
194.00	07950	HOMEBOUND MEALS	0	0	44,663	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,549	0	91,315	1	3	194.01
194.02	07952	FOUNDATION	200	947	47,122	1	1	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
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)	612,008	352,800	2,554,747	125,167	553,554	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.859923	1.046692	0.233232	451.866426	3,334.662651	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	1,667	16,872	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	6.018051	101.638554	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.04	5.04	7.00	8.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	45,216,636					5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	-1,699,413	20,347,739			5.04
7.00	00700	OPERATION OF PLANT	0	0	866,470	58,357		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	68,627	0	93,177	8.00
9.00	00900	HOUSEKEEPING	0	0	307,216	1,215	0	9.00
10.00	01000	DIETARY	0	0	110,399	1,961	0	10.00
11.00	01100	CAFETERIA	0	0	73,583	450	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	398,240	595	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	87,869	735	0	14.00
15.00	01500	PHARMACY	0	0	389,024	761	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	280,054	602	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	62,853	163	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	233,545	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,175,467	0	1,127,932	7,721	35,553	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,664,607	0	754,058	3,598	4,518	50.00
53.00	05300	ANESTHESIOLOGY	711,039	0	35,932	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,089,491	0	1,942,952	3,523	9,019	54.00
60.00	06000	LABORATORY	9,923,303	0	1,408,585	1,032	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,387,352	0	827,016	3,333	357	65.00
66.00	06600	PHYSICAL THERAPY	2,715,604	0	906,502	7,807	15,192	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,103	0	10,248	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,629,802	0	1,272,396	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	0	2,731,380	5,789	0	88.00
91.00	09100	EMERGENCY	4,755,868	0	2,102,806	3,310	28,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,258,693	3,280	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	780,745	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,216,636	-1,699,413	18,037,125	45,875	93,177	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	2,441	224	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,918,038	10,509	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	95,256	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	170,651	1,549	0	194.01
194.02	07952	FOUNDATION	0	0	66,495	200	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	57,733	0	0	194.03
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)	785,470		1,699,413	938,837	74,359	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.017371		0.083519	16.087822	0.798040	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,845		48,135	153,862	162	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000328		0.002366	2.636565	0.001739	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	48,617					9.00
10.00	01000	DIETARY	1,961	5,050				10.00
11.00	01100	CAFETERIA	450	0	242,923			11.00
13.00	01300	NURSING ADMINISTRATION	595	0	6,240	141,939		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	0	2,205	0	550,883	14.00
15.00	01500	PHARMACY	761	0	4,867	4,867	1,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602	0	6,302	0	2,129	16.00
17.00	01700	SOCIAL SERVICE	163	0	2,018	2,018	81	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,726	1,726	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,721	5,050	25,480	25,480	33,218	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,598	0	8,549	8,549	103,779	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523	0	17,659	17,659	58,676	54.00
60.00	06000	LABORATORY	1,032	0	20,488	20,488	129,903	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,333	0	18,200	18,200	32,970	65.00
66.00	06600	PHYSICAL THERAPY	7,807	0	17,826	17,826	7,692	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26,351	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	4,023	0	33,967	0	26,497	88.00
91.00	09100	EMERGENCY	3,310	0	25,126	25,126	63,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,280	0	2,392	0	34,278	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	2,080	0	1,400	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,894	5,050	195,125	141,939	528,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	224	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,750	0	40,414	0	20,909	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,549	0	5,262	0	1,608	194.01
194.02	07952	FOUNDATION	200	0	2,122	0	78	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
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)	352,421	165,382	90,231	447,704	113,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.248925	32.748911	0.371439	3.154200	0.205452	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,373	26,568	4,562	7,184	7,524	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.254499	5.260990	0.018780	0.050613	0.013658	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/8/2019 8:37 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			15.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,191,972					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,050,138				16.00
17.00	01700	SOCIAL SERVICE	0	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,175,467	80	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,664,607	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	711,039	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,089,491	0	0		54.00
60.00	06000	LABORATORY	0	9,923,303	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	3,387,352	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,715,604	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	164,103	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,191,972	4,629,802	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	0	0	0		88.00
91.00	09100	EMERGENCY	0	4,755,868	20	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,629,085	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,204,417	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,191,972	48,050,138	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0		194.03
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)	456,837	320,271	79,038	259,135		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.383262	0.006665	790.380000	2,591.350000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,359	8,041	1,987	672		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010369	0.000167	19.870000	6.720000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-2 | Date/Time Prepared: 5/8/2019 8:37 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & RECOVERY ROOM	1	30.00	-71,739	7.00
8.00		IV THERAPY	1	64.00	70,004	8.00
9.00		RECOVERY ROOM	1	50.00	1,735	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,698,723		1,698,723	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	975,565		975,565	0	0	50.00
53.00	05300	ANESTHESIOLOGY	303,946		303,946	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,362,874		2,362,874	0	0	54.00
60.00	06000	LABORATORY	1,715,373		1,715,373	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	70,004		70,004	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,067,672	0	1,067,672	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,259,054	0	1,259,054	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,612		17,612	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,360		1,866,360	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	3,099,845		3,099,845	0	0	88.00
91.00	09100	EMERGENCY	2,527,649		2,527,649	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,668		44,668		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,459,150		1,459,150		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	855,040		855,040		0	116.00
200.00		Subtotal (see instructions)	19,323,535	0	19,323,535	0	0	200.00
201.00		Less Observation Beds	44,668		44,668		0	201.00
202.00		Total (see instructions)	19,278,867	0	19,278,867	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,485,070		1,485,070			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,755	2,612,240	2,614,995	0.373066	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,835	660,582	685,417	0.443447	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449,034	13,455,329	13,904,363	0.169938	0.000000	54.00
60.00	06000	LABORATORY	748,113	9,071,714	9,819,827	0.174685	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	204,521	418,127	622,648	0.112429	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,577,681	1,848,553	3,426,234	0.311617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	177,294	2,481,684	2,658,978	0.473510	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,965	38,986	163,951	0.107422	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	633,392	3,973,658	4,607,050	0.405110	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	1,996,197	1,996,197			88.00
91.00	09100	EMERGENCY	244,942	4,456,654	4,701,596	0.537615	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,450	22,564	44,014	1.014859	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,629,085	1,629,085			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,204,417	1,204,417			116.00
200.00		Subtotal (see instructions)	5,694,052	43,869,790	49,563,842			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,694,052	43,869,790	49,563,842			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
60.00	06000	LABORATORY	0.000000
64.00	06400	INTRAVENOUS THERAPY	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RHCS (CONSOLIDATED)	
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000
		OTHER REIMBURSABLE COST CENTERS	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
116.00	11600	HOSPICE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XIX | Hospital

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,698,723		1,698,723	0	1,698,723	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	975,565		975,565	0	975,565	50.00
53.00	05300	ANESTHESIOLOGY	303,946		303,946	0	303,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,362,874		2,362,874	0	2,362,874	54.00
60.00	06000	LABORATORY	1,715,373		1,715,373	0	1,715,373	60.00
64.00	06400	INTRAVENOUS THERAPY	70,004		70,004	0	70,004	64.00
65.00	06500	RESPIRATORY THERAPY	1,067,672	0	1,067,672	0	1,067,672	65.00
66.00	06600	PHYSICAL THERAPY	1,259,054	0	1,259,054	0	1,259,054	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,612		17,612	0	17,612	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,360		1,866,360	0	1,866,360	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	3,099,845		3,099,845	0	3,099,845	88.00
91.00	09100	EMERGENCY	2,527,649		2,527,649	0	2,527,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,668		44,668		44,668	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,459,150		1,459,150		1,459,150	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	855,040		855,040		855,040	116.00
200.00		Subtotal (see instructions)	19,323,535	0	19,323,535	0	19,323,535	200.00
201.00		Less Observation Beds	44,668		44,668		44,668	201.00
202.00		Total (see instructions)	19,278,867	0	19,278,867	0	19,278,867	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XIX | Hospital

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,485,070		1,485,070			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,755	2,612,240	2,614,995	0.373066	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,835	660,582	685,417	0.443447	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449,034	13,455,329	13,904,363	0.169938	0.000000	54.00
60.00	06000	LABORATORY	748,113	9,071,714	9,819,827	0.174685	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	204,521	418,127	622,648	0.112429	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,577,681	1,848,553	3,426,234	0.311617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	177,294	2,481,684	2,658,978	0.473510	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,965	38,986	163,951	0.107422	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	633,392	3,973,658	4,607,050	0.405110	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	1,996,197	1,996,197	1.552875	0.000000	88.00
91.00	09100	EMERGENCY	244,942	4,456,654	4,701,596	0.537615	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,450	22,564	44,014	1.014859	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,629,085	1,629,085			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,204,417	1,204,417			116.00
200.00		Subtotal (see instructions)	5,694,052	43,869,790	49,563,842			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,694,052	43,869,790	49,563,842			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/8/2019 8:37 am

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RHCS (CONSOLIDATED)	0.000000	88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	178,406	2,614,995	0.068224	2,755	188	50.00
53.00	05300	ANESTHESIOLOGY	11,452	685,417	0.016708	18,223	304	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,818	13,904,363	0.012717	328,448	4,177	54.00
60.00	06000	LABORATORY	58,247	9,819,827	0.005932	532,871	3,161	60.00
64.00	06400	INTRAVENOUS THERAPY	0	622,648	0.000000	131,485	0	64.00
65.00	06500	RESPIRATORY THERAPY	71,293	3,426,234	0.020808	1,019,590	21,216	65.00
66.00	06600	PHYSICAL THERAPY	94,876	2,658,978	0.035681	57,829	2,063	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	465	163,951	0.002836	86,922	247	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,327	4,607,050	0.007668	416,217	3,192	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	79,563	1,996,197	0.039857	0	0	88.00
91.00	09100	EMERGENCY	56,580	4,701,596	0.012034	10,007	120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,063	44,014	0.069591	0	0	92.00
200.00		Total (lines 50 through 199)	766,090	45,245,270		2,604,347	34,668	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	259,135	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	259,135	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,614,995	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	259,135	0	685,417	0.378069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,904,363	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,819,827	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	622,648	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,426,234	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,658,978	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	163,951	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,607,050	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0	0	0	1,996,197	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	4,701,596	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	44,014	0.000000	92.00
200.00		Total (lines 50 through 199)	0	259,135	0	45,245,270		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,755	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	18,223	6,890	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	328,448	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	532,871	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	131,485	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,019,590	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	57,829	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	86,922	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	416,217	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	10,007	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,604,347	6,890	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.373066	0	1,151,104	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.443447	0	299,526	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169938	0	5,648,314	0	0	54.00
60.00	06000	LABORATORY	0.174685	0	3,971,348	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.112429	0	237,684	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.311617	0	989,225	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.473510	0	939,151	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.107422	0	17,046	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405110	0	2,864,064	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0.000000				0	88.00
91.00	09100	EMERGENCY	0.537615	0	1,787,369	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.014859	0	21,657	0	0	92.00
200.00		Subtotal (see instructions)		0	17,926,488	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	17,926,488	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	429,438	0		50.00
53.00	05300	ANESTHESIOLOGY	132,824	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,863	0		54.00
60.00	06000	LABORATORY	693,735	0		60.00
64.00	06400	INTRAVENOUS THERAPY	26,723	0		64.00
65.00	06500	RESPIRATORY THERAPY	308,259	0		65.00
66.00	06600	PHYSICAL THERAPY	444,697	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,831	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,160,261	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHCS (CONSOLIDATED)	0	0		88.00
91.00	09100	EMERGENCY	960,916	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,979	0		92.00
200.00		Subtotal (see instructions)	5,140,526	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,140,526	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.373066	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.443447	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169938	0	0	0	0	54.00
60.00	06000	LABORATORY	0.174685	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.112429	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.311617	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.473510	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.107422	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405110	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHCS (CONSOLIDATED)	0.000000				0	88.00
91.00	09100	EMERGENCY	0.537615	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.014859	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		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: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHCS (CONSOLIDATED)	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,327	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,283	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	344	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	15	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)	903	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)	308	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	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,698,723	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,331	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)	351,560	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,347,163	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)	1,347,163	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,015.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	916,726	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)	916,726	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/8/2019 8:37 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)	701,229	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,617,955	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	312,682	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)	312,682	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)	44	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,015.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	44,668	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	116,489	1,698,723	0.068574	44,668	3,063	90.00
91.00	Nursing School cost	0	1,698,723	0.000000	44,668	0	91.00
92.00	Allied health cost	0	1,698,723	0.000000	44,668	0	92.00
93.00	All other Medical Education	0	1,698,723	0.000000	44,668	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		895,365		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.373066	2,755	1,028	50.00
53.00	05300	ANESTHESIOLOGY	0.443447	18,223	8,081	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169938	328,448	55,816	54.00
60.00	06000	LABORATORY	0.174685	532,871	93,085	60.00
64.00	06400	INTRAVENOUS THERAPY	0.112429	131,485	14,783	64.00
65.00	06500	RESPIRATORY THERAPY	0.311617	1,019,590	317,722	65.00
66.00	06600	PHYSICAL THERAPY	0.473510	57,829	27,383	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.107422	86,922	9,337	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405110	416,217	168,614	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHCS (CONSOLIDATED)	0.000000		0	88.00
91.00	09100	EMERGENCY	0.537615	10,007	5,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.014859	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,604,347	701,229	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)		2,604,347		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.373066	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.443447	268	119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169938	13,559	2,304	54.00
60.00	06000	LABORATORY	0.174685	56,921	9,943	60.00
64.00	06400	INTRAVENOUS THERAPY	0.112429	7,650	860	64.00
65.00	06500	RESPIRATORY THERAPY	0.311617	193,093	60,171	65.00
66.00	06600	PHYSICAL THERAPY	0.473510	91,692	43,417	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.107422	4,580	492	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405110	64,141	25,984	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHCS (CONSOLIDATED)	0.000000		0	88.00
91.00	09100	EMERGENCY	0.537615	755	406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.014859	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		432,659	143,696	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)		432,659		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/8/2019 8:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,140,526	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)	5,140,526	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,191,931	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)	51,182	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,753,000	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)	2,387,749	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)	2,387,749	30.00
31.00	Primary payer payments	697	31.00
32.00	Subtotal (line 30 minus line 31)	2,387,052	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)	446,751	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	290,388	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	364,680	36.00
37.00	Subtotal (see instructions)	2,677,440	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,677,440	40.00
40.01	Sequestration adjustment (see instructions)	53,549	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,372,261	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	251,630	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/8/2019 8:37 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		1,386,920		2,655,560	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	07/09/2018	73,585	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	11/19/2018	37,309	11/19/2018	356,884	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)		-37,309		-283,299	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,349,611		2,372,261	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		54,504		251,630	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,404,115		2,623,891	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: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/8/2019 8:37 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		417,447		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/19/2018	21,638		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)		-21,638		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)		395,809		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		55,586		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		451,395		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: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/8/2019 8:37 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: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/8/2019 8:37 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)	315,809	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)	145,133	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	308	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)	460,942	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	460,942	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)	460,942	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	335	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)	460,607	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)	460,607	0	19.00
19.01	Sequestration adjustment (see instructions)	9,212	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	395,809	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)	55,586	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1341	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/8/2019 8:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,617,955	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)	1,617,955	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,634,135	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)	1,634,135	19.00
20.00	Deductibles (exclude professional component)	243,832	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,390,303	22.00
23.00	Coinsurance	1,340	23.00
24.00	Subtotal (line 22 minus line 23)	1,388,963	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	67,395	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	43,807	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	61,115	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,432,770	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,432,770	30.00
30.01	Sequestration adjustment (see instructions)	28,655	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,349,611	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)	54,504	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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/8/2019 8:37 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	5,881,554	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	5,130,197	0	0	0	4.00
5.00	Other receivable	39,020	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,365,080	0	0	0	6.00
7.00	Inventory	482,181	0	0	0	7.00
8.00	Prepaid expenses	206,437	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	555,724	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,930,033	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	51,361	0	0	0	12.00
13.00	Land improvements	864,526	0	0	0	13.00
14.00	Accumulated depreciation	-367,976	0	0	0	14.00
15.00	Buildings	11,230,711	0	0	0	15.00
16.00	Accumulated depreciation	-6,575,937	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	599,547	0	0	0	19.00
20.00	Accumulated depreciation	-512,550	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,030,377	0	0	0	23.00
24.00	Accumulated depreciation	-6,760,016	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	17,092,466	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,652,509	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,102,057	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	22,138	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,124,195	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,706,737	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,666,677	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,020,868	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	101,860	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,789,405	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,519,117	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)	3,519,117	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,308,522	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,398,215				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)	29,398,215	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,706,737	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/8/2019 8:37 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		28,089,964		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,316,671				2.00
3.00	Total (sum of line 1 and line 2)		29,406,635		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,406,635		0		11.00
12.00	QUAD COUNTY HOME MEDICAL SVS	8,420		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)		8,420		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,398,215		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	QUAD COUNTY HOME MEDICAL SVS		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: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/8/2019 8:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,242,161		1,242,161	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	235,640		235,640	5.00
6.00	Swing bed - NF	10,275		10,275	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)	1,488,076		1,488,076	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)	1,488,076		1,488,076	17.00
18.00	Ancillary services	3,942,590	34,697,827	38,640,417	18.00
19.00	Outpatient services	266,392	4,533,490	4,799,882	19.00
20.00	RHCS (CONSOLIDATED)	0	1,996,353	1,996,353	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,629,085	1,629,085	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	141,575	1,062,842	1,204,417	26.00
27.00	PROFESSIONAL FEES	801,573	7,005,871	7,807,444	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,640,206	50,925,468	57,565,674	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,556,663		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,556,663		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/8/2019 8:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	57,565,674	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,698,559	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,867,115	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,556,663	4.00
5.00	Net income from service to patients (line 3 minus line 4)	310,452	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	498,718	6.00
7.00	Income from investments	257,687	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	35,510	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	37,105	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	6,806	21.00
22.00	Rental of hospital space	64,772	22.00
23.00	Governmental appropriations	37,489	23.00
24.00	MISCELLANEOUS REVENUE	4,961	24.00
24.01	RETAIL PHARMACY	322,684	24.01
24.02	FITNESS CENTER REVENUE	95,577	24.02
25.00	Total other income (sum of lines 6-24)	1,361,309	25.00
26.00	Total (line 5 plus line 25)	1,671,761	26.00
27.00	LOSS ON SALE OF ASSET	2,352	27.00
27.01	UNREALIZED GAIN ON INVESTMENTS	352,738	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	355,090	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,316,671	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1341 HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H Date/Time Prepared: 5/8/2019 8:37 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	126,104	0	62,940	0	52,692	241,736	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	386,149	0	0	0	0	386,149	6.00
7.00	Physical Therapy	143,313	0	0	128,480	0	271,793	7.00
8.00	Occupational Therapy	53,986	0	0	32,834	0	86,820	8.00
9.00	Speech Pathology	6,250	0	0	2,895	0	9,145	9.00
10.00	Medical Social Services	4,923	0	0	0	0	4,923	10.00
11.00	Home Health Aide	2,869	0	0	0	0	2,869	11.00
12.00	Supplies (see instructions)	0	0	0	0	21,772	21,772	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	723,594	0	62,940	164,209	74,464	1,025,207	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-3,877	237,859	0	237,859			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	386,149	0	386,149			6.00
7.00	Physical Therapy	0	271,793	0	271,793			7.00
8.00	Occupational Therapy	0	86,820	0	86,820			8.00
9.00	Speech Pathology	0	9,145	0	9,145			9.00
10.00	Medical Social Services	0	4,923	0	4,923			10.00
11.00	Home Health Aide	0	2,869	0	2,869			11.00
12.00	Supplies (see instructions)	0	21,772	0	21,772			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-3,877	1,021,330	0	1,021,330			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 5/8/2019 8:37 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	237,859	0	0	0	0	237,859	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	386,149	0	0	0	0	386,149	6.00
7.00	Physical Therapy	271,793	0	0	0	0	271,793	7.00
8.00	Occupational Therapy	86,820	0	0	0	0	86,820	8.00
9.00	Speech Pathology	9,145	0	0	0	0	9,145	9.00
10.00	Medical Social Services	4,923	0	0	0	0	4,923	10.00
11.00	Home Health Aide	2,869	0	0	0	0	2,869	11.00
12.00	Supplies (see instructions)	21,772	0	0	0	0	21,772	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,021,330	0	0	0	0	1,021,330	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	237,859			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	117,234	503,383		6.00
7.00	Physical Therapy	82,515	354,308		7.00
8.00	Occupational Therapy	26,358	113,178		8.00
9.00	Speech Pathology	2,776	11,921		9.00
10.00	Medical Social Services	1,495	6,418		10.00
11.00	Home Health Aide	871	3,740		11.00
12.00	Supplies (see instructions)	6,610	28,382		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		1,021,330		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II | Date/Time Prepared: 5/8/2019 8:37 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-237,859	783,471	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	386,149	6.00
7.00	Physical Therapy	0	0	0	0	0	271,793	7.00
8.00	Occupational Therapy	0	0	0	0	0	86,820	8.00
9.00	Speech Pathology	0	0	0	0	0	9,145	9.00
10.00	Medical Social Services	0	0	0	0	0	4,923	10.00
11.00	Home Health Aide	0	0	0	0	0	2,869	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	21,772	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-237,859	783,471	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		237,859	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.303596	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341 HHA CCN: 14-7299

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

Worksheet H-2 Part I Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	16,546	2,638	29,411	452	3,335	1.00
2.00	Skilled Nursing Care	503,383	0	0	90,063	4,066	26,677	2.00
3.00	Physical Therapy	354,308	0	0	33,425	904	0	3.00
4.00	Occupational Therapy	113,178	0	0	12,591	452	0	4.00
5.00	Speech Pathology	11,921	0	0	1,458	0	0	5.00
6.00	Medical Social Services	6,418	0	0	1,148	0	0	6.00
7.00	Home Health Aide	3,740	0	0	669	0	0	7.00
8.00	Supplies (see instructions)	28,382	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	5,955	0	0	904	6,669	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,021,330	22,501	2,638	168,765	6,778	36,681	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.03	5A.03	5.04	7.00	8.00	9.00	
1.00	Administrative and General	0	52,382	4,375	0	0	0	1.00
2.00	Skilled Nursing Care	0	624,189	52,132	38,804	0	17,484	2.00
3.00	Physical Therapy	0	388,637	32,459	0	0	0	3.00
4.00	Occupational Therapy	0	126,221	10,542	0	0	0	4.00
5.00	Speech Pathology	0	13,379	1,117	0	0	0	5.00
6.00	Medical Social Services	0	7,566	632	0	0	0	6.00
7.00	Home Health Aide	0	4,409	368	0	0	0	7.00
8.00	Supplies (see instructions)	0	28,382	2,370	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	13,528	1,130	13,964	0	6,292	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	1,258,693	105,125	52,768	0	23,776	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	888	0	0	0	10,858	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	7,042	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	888	0	7,042	0	10,858	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		17.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	56,757	0	56,757		1.00
2.00	Skilled Nursing Care	0	0	744,355	0	744,355	30,124	2.00
3.00	Physical Therapy	0	0	421,096	0	421,096	17,043	3.00
4.00	Occupational Therapy	0	0	136,763	0	136,763	5,535	4.00
5.00	Speech Pathology	0	0	14,496	0	14,496	587	5.00
6.00	Medical Social Services	0	0	8,198	0	8,198	332	6.00
7.00	Home Health Aide	0	0	4,777	0	4,777	193	7.00
8.00	Supplies (see instructions)	0	0	37,794	0	37,794	1,530	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	34,914	0	34,914	1,413	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,459,150	0	1,459,150	56,757	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.040472	21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341
HHA CCN: 14-7299

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

Worksheet H-2 Part I
Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	774,479				2.00
3.00	Physical Therapy	438,139				3.00
4.00	Occupational Therapy	142,298				4.00
5.00	Speech Pathology	15,083				5.00
6.00	Medical Social Services	8,530				6.00
7.00	Home Health Aide	4,970				7.00
8.00	Supplies (see instructions)	39,324				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	36,327				19.00
19.50	Telemedicine	0				19.50
20.00	Total (sum of lines 1-19) (2)	1,459,150				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part II | Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	2,412	2,520	126,104	1	1	0	1.00
2.00	Skilled Nursing Care	0	0	386,149	9	8	0	2.00
3.00	Physical Therapy	0	0	143,313	2	0	0	3.00
4.00	Occupational Therapy	0	0	53,986	1	0	0	4.00
5.00	Speech Pathology	0	0	6,250	0	0	0	5.00
6.00	Medical Social Services	0	0	4,923	0	0	0	6.00
7.00	Home Health Aide	0	0	2,869	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	868	0	0	2	2	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,280	2,520	723,594	15	11	0	20.00
21.00	Total cost to be allocated	22,501	2,638	168,765	6,778	36,681	0	21.00
22.00	Unit cost multiplier	6.860061	1.046825	0.233232	451.866667	3,334.636364	0.000000	22.00

	Cost Center Description	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.04	5.04	7.00	8.00	9.00	10.00	
1.00	Administrative and General	0	52,382	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	624,189	2,412	0	2,412	0	2.00
3.00	Physical Therapy	0	388,637	0	0	0	0	3.00
4.00	Occupational Therapy	0	126,221	0	0	0	0	4.00
5.00	Speech Pathology	0	13,379	0	0	0	0	5.00
6.00	Medical Social Services	0	7,566	0	0	0	0	6.00
7.00	Home Health Aide	0	4,409	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	28,382	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	13,528	868	0	868	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)		1,258,693	3,280	0	3,280	0	20.00
21.00	Total cost to be allocated		105,125	52,768	0	23,776	0	21.00
22.00	Unit cost multiplier		0.083519	16.087805	0.000000	7.248780	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341 HHA CCN: 14-7299

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

Worksheet H-2 Part II Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	2,392	0	0	0	1,629,085	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	34,278	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,392	0	34,278	0	1,629,085	0	20.00
21.00	Total cost to be allocated	888	0	7,042	0	10,858	0	21.00
22.00	Unit cost multiplier	0.371237	0.000000	0.205438	0.000000	0.006665	0.000000	22.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	774,479		774,479	3,705	209.04	1.00
2.00	Physical Therapy	3.00	438,139	0	438,139	3,373	129.90	2.00
3.00	Occupational Therapy	4.00	142,298	0	142,298	862	165.08	3.00
4.00	Speech Pathology	5.00	15,083	0	15,083	76	198.46	4.00
5.00	Medical Social Services	6.00	8,530		8,530	71	120.14	5.00
6.00	Home Health Aide	7.00	4,970		4,970	97	51.24	6.00
7.00	Total (sum of lines 1-6)		1,383,499	0	1,383,499	8,184		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	2,201			8.00
9.00	Physical Therapy		99914	0	2,526			9.00
10.00	Occupational Therapy		99914	0	655			10.00
11.00	Speech Pathology		99914	0	48			11.00
12.00	Medical Social Services		99914	0	38			12.00
13.00	Home Health Aide		99914	0	84			13.00
14.00	Total (sum of lines 8-13)			0	5,552			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	39,324	0	39,324	14,802	2.656668	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,201		0	460,097		1.00
2.00	Physical Therapy	0	2,526		0	328,127		2.00
3.00	Occupational Therapy	0	655		0	108,127		3.00
4.00	Speech Pathology	0	48		0	9,526		4.00
5.00	Medical Social Services	0	38		0	4,565		5.00
6.00	Home Health Aide	0	84		0	4,304		6.00
7.00	Total (sum of lines 1-6)	0	5,552		0	914,746		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1341 HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 5/8/2019 8:37 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	8,114	0	0	21,556	0	15.00
16.00	Cost of Drugs	0	0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	460,097	1.00
2.00	Physical Therapy	328,127	2.00
3.00	Occupational Therapy	108,127	3.00
4.00	Speech Pathology	9,526	4.00
5.00	Medical Social Services	4,565	5.00
6.00	Home Health Aide	4,304	6.00
7.00	Total (sum of lines 1-6)	914,746	7.00
	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341
HHA CCN: 14-7299

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

Worksheet H-3
Part II
Date/Time Prepared:
5/8/2019 8:37 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.473510	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.107422	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.405110	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/8/2019 8:37 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,047,558	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	14,351	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	15,394	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,325	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	4,309	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,087,937	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,087,937	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,087,937	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,087,937	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,087,937	31.00
31.01	Sequestration adjustment (see instructions)	0	21,759	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,066,178	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 5/8/2019 8:37 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,066,178	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,066,178	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,066,178	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	0	0	0	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	26,114	0	26,114	0	26,114	13.00
14.00	PHARMACY*	75,191	93,923	169,114	-5,804	163,310	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	3,300	0	3,300	0	3,300	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	196,744	0	196,744	0	196,744	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	52,978	0	52,978	0	52,978	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	13,347	0	13,347	0	13,347	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	32,541	0	32,541	0	32,541	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	94,883	227	95,110	0	95,110	42.00
42.50	DRUGS CHARGED TO PATIENTS**	75,819	182	76,001	0	76,001	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	570,917	94,332	665,249	-5,804	659,445	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	0		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	26,114		13.00
14.00	PHARMACY*	0	163,310		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	3,300		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	20,384	217,128		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	52,978		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	13,347		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	32,541		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	95,110		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	76,001		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	20,384	679,829		100.00

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

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

Provider CCN: 14-1341 Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-2 Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	3,292	0	3,292	0	3,292	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	196,275	0	196,275	0	196,275	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	52,852	0	52,852	0	52,852	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	13,315	0	13,315	0	13,315	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	32,463	0	32,463	0	32,463	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	94,883	0	94,883	0	94,883	42.00
42.50	DRUGS CHARGED TO PATIENTS	75,819	0	75,819	0	75,819	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	468,899	0	468,899	0	468,899	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	3,292		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	20,355	216,630		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	52,852		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	13,315		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	32,463		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	94,883		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	75,819		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	20,355	489,254		100.00

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

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

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-3 | Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	3	0	3	0	3	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	164	0	164	0	164	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	44	0	44	0	44	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	11	0	11	0	11	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	27	0	27	0	27	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	79	79	0	79	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	64	64	0	64	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	249	143	392	0	392	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	3		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	164		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	44		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	11		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	27		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	79		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	64		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	392		100.00

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

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

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-4 | Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	5	0	5	0	5	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	305	0	305	0	305	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	82	0	82	0	82	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	21	0	21	0	21	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	51	0	51	0	51	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	148	148	0	148	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	118	118	0	118	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	464	266	730	0	730	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	5		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	29	334		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	82		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	21		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	51		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	148		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	118		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	29	759		100.00

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

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

Provider CCN: 14-1341 Hospice CCN: 14-1575

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

Worksheet O-5

Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	93,343	93,343	3.00
4.00	ADMINISTRATIVE & GENERAL	0	73,553	73,553	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	288	288	10.00
11.00	MEDICAL RECORDS	0	8,027	8,027	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	26,114		26,114	13.00
14.00	PHARMACY	163,310	0	163,310	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	489,254		489,254	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	392		392	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	759		759	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	679,829	175,211	855,040	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6
Part I
Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	93,343	0	0	93,343		3.00
4.00	ADMINISTRATIVE & GENERAL	73,553	0	0	23,290	96,843	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	288	0	0	0	288	10.00
11.00	MEDICAL RECORDS	8,027	0	0	0	8,027	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	26,114	0	0	8,089	34,203	13.00
14.00	PHARMACY	163,310	0	0	0	163,310	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	489,254			61,816	551,070	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	392	0	0	96	488	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	759	0	0	52	811	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	855,040	0	0	93,343	855,040	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6 Part I
Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	96,843					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	37	0		0		10.00
11.00	MEDICAL RECORDS	1,025	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	4,369	0		0		13.00
14.00	PHARMACY	20,859	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	70,387					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	62	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	104	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	96,843	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6 Part I
Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	325				10.00
11.00	MEDICAL RECORDS	0		9,052			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	38,572	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	324	9,030	0	38,480	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	14	0	60	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	8	0	32	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	325	9,052	0	38,572	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6 Part I
Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	184,169					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	184,169	0	0		853,460	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	625	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	955	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	184,169	0	0	0	855,040	100.00

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

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6
Part II
Date/Time Prepared:
5/8/2019 8:37 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	301,349			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	75,191	-96,843	758,197	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	288	10.00
11.00	MEDICAL RECORDS	0	0	0	0	8,027	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	26,114	0	34,203	13.00
14.00	PHARMACY	0	0	0	0	163,310	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			199,567	0	551,070	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	310	0	488	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	167	0	811	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	93,343		96,843	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.309750		0.127728	101.00

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

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6
Part II
Date/Time Prepared:
5/8/2019 8:37 am

Hospice I

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

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

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	8,375					10.00
11.00	MEDICAL RECORDS		8,375				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	8,375		13.00
14.00	PHARMACY			0	0	59,022	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	8,355	8,355	0	8,355	59,022	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	13	13	0	13	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7	7	0	7	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	325	9,052	0	38,572	184,169	100.00
101.00	UNIT COST MULTIPLIER	0.038806	1.080836	0.000000	4.605612	3.120345	101.00

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

Provider CCN: 14-1341
Hospice CCN: 14-1575

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

Worksheet O-6
Part II
Date/Time Prepared:
5/8/2019 8:37 am

Hospice I

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

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

Provider CCN: 14-1341 Hospice CCN: 14-1575

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

Worksheet O-7

Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.473510	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.405110	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.174685	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.107422	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-8 | Date/Time Prepared: 5/8/2019 8:37 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			853,460	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			8,355	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			102.15	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,672	728		9.00
10.00	Program cost (line 8 times line 9)	681,545	74,365		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			625	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			13	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			48.08	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	12	0		14.00
15.00	Program cost (line 13 times line 14)	577	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			955	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			7	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			136.43	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	0		19.00
20.00	Program cost (line 18 times line 19)	955	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			855,040	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			8,375	22.00
23.00	Average cost per diem (line 21 divided by line 22)			102.09	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/8/2019 8:37 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	907,164	0	907,164	0	907,164	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	298,703	0	298,703	0	298,703	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	317,162	0	317,162	0	317,162	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	553	0	553	0	553	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,523,582	0	1,523,582	0	1,523,582	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	167,411	167,411	0	167,411	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	167,411	167,411	0	167,411	14.00
15.00	Medical Supplies	0	80,288	80,288	0	80,288	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	27,416	27,416	0	27,416	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	107,704	107,704	0	107,704	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,523,582	275,115	1,798,697	0	1,798,697	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	2,352	2,352	0	2,352	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,352	2,352	0	2,352	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	53,461	53,461	0	53,461	29.00
30.00	Administrative Costs	245,078	109,097	354,175	2,553	356,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	245,078	162,558	407,636	2,553	410,189	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,768,660	440,025	2,208,685	2,553	2,211,238	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/8/2019 8:37 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	-8,084	899,080		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	298,703		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	317,162		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	553		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-8,084	1,515,498		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	167,411		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	167,411		14.00
15.00	Medical Supplies	0	80,288		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	27,416		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	107,704		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,084	1,790,613		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	2,352		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,352		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	53,461		29.00
30.00	Administrative Costs	0	356,728		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	410,189		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,084	2,203,154		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/8/2019 8:37 am

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	2.17	9,453	4,200	9,114		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.99	3,804	2,100	4,179		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.16	13,257		13,293	13,293	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	0.01	360			360	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)	4.17	13,617			13,653	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,790,613	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,352	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,792,965	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998688	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					410,189	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					896,691	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,306,880	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,306,880	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,305,165	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,095,778	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/8/2019 8:37 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)			3,095,778	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			63,827	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,031,951	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,653	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)			13,653	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.07	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	222.07	222.07		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,351		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	744,157		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	45		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	9,993		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	9,993		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	754,150		16.00
16.01	Total program charges (see instructions)(from contractor's records)		703,653		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		39,098		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		41,904		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.)		519,285		16.04
16.05	Total program cost (see instructions)	0	561,189		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		63,140		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		120,286		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		561,189		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,870		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		590,059		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		590,059		26.00
26.01	Sequestration adjustment (see instructions)		11,801		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		503,415		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)		74,843		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

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

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/8/2019 8:37 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)	1,515,498	1,515,498	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000447	0.001381	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	677	2,093	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	26,172	7,976	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	26,849	10,069	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,790,613	1,790,613	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,305,165	1,305,165	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.014994	0.005623	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	19,570	7,339	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	46,419	17,408	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	162	500	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	286.54	34.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	79	179	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	22,637	6,233	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)		63,827	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)		28,870	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/8/2019 8:37 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		503,415	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		503,415	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		74,843	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		578,258	7.00

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