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: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 10/22/2018 2:10 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/22/2018 Time: 2:10 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (14-1349) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	16,862	-111,796	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	98,725	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	RURAL HEALTH CLINIC I	0		468,750		0	10.00
200.00	Total	0	115,587	356,954	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 818 EAST BROADWAY	PO Box:			1.00
2.00	City: SPARTA	State: IL	Zip Code: 62286	County: RANDOLPH	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	SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	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	SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	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	SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	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)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 10/22/2018 2:07 pm

		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)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

	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	

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		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)	N	N	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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.	N		108.00

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		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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	420,126	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 10/22/2018 2:07 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	09/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 10/22/2018 2:07 pm

		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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 10/22/2018 2:07 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N	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	09/04/2018	Y	09/04/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 10/22/2018 2:07 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		211 N BROADWAY STE 600, ST LOUIS, MO		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 10/22/2018 2:07 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	31,712.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	31,712.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	31,712.00	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						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)		25				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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	840	106	1,330			1.00
2.00	HMO and other (see instructions)	49	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	565	0	639			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,405	106	1,985			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)	1,405	106	1,985	0.00	192.78	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	4,089	0	7,160	0.00	12.87	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	31			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	13,157	0	46,774	0.00	69.77	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	275.42	27.00
28.00	Observation Bed Days		29	382			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			8			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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	278	36	454	1.00
2.00	HMO and other (see instructions)			16	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	278	36	454	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						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: 14-1349 | Component CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-4 | Date/Time Prepared: 10/22/2018 2:07 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	269.00	76.00	187.00	532.00	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)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			3.74	0.00	3.74	5.00
6.00	Direct Nursing Service			6.68	0.00	6.68	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.30	0.00	2.30	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.16	0.00	0.16	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.05	0.05	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16060			20.00
20.01				41180			20.01
20.02				99914			20.02
		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	1,899	92	33	34	2,058	21.00
22.00	Skilled Nursing Visit Charges	566,658	26,490	10,964	10,277	614,389	22.00
23.00	Physical Therapy Visits	1,778	7	12	44	1,841	23.00
24.00	Physical Therapy Visit Charges	430,021	1,828	4,147	10,647	446,643	24.00
25.00	Occupational Therapy Visits	136	0	0	3	139	25.00
26.00	Occupational Therapy Visit Charges	40,276	0	0	890	41,166	26.00
27.00	Speech Pathology Visits	49	0	0	0	49	27.00
28.00	Speech Pathology Visit Charges	14,529	0	0	0	14,529	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	2	0	0	0	2	31.00
32.00	Home Health Aide Visit Charges	328	0	0	0	328	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,864	99	45	81	4,089	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)	1,051,812	28,318	15,111	21,814	1,117,055	35.00
36.00	Total Number of Episodes (standard/non outlier)	286		16	5	307	36.00
37.00	Total Number of Outlier Episodes		4		1	5	37.00
38.00	Total Non-Routine Medical Supply Charges	12,335	979	107	159	13,580	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1349
Component CCN: 14-3464

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

Worksheet S-8

Date/Time Prepared: 10/22/2018 2:07 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1300 NORTH MARKET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SPARTA	IL	62286	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	09:00	14:00	09:00	19:00	09:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number	WOMENS HEALTH CLINIC	143464	14.00
14.01		COULTERVILLE MEDICAL CLINIC	143465	14.01
14.02		FAMILY HEALTH CLINIC	143466	14.02
14.03		STEELEVILLE CLINIC	143467	14.03
14.04		MARISSA MEDICAL CLINIC	143490	14.04
14.05		SPARTA MEDICAL OFFICE	143489	14.05

		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	RANDOLPH		2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 10/22/2018 2:07 pm

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	19:00	09:00	19:00	09:00	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	19:00	09:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 10/22/2018 2:07 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.399923	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,822,979	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	2,622,689	5.00
6.00	Medicaid charges	12,184,455	6.00
7.00	Medicaid cost (line 1 times line 6)	4,872,844	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	75,921	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)	99,523	5,554	105,077	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	39,802	5,554	45,356	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	39,802	5,554	45,356	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)	3,565,382	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	442,430	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	680,661	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,884,721	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,391,897	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,437,253	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,437,253	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		697,660	697,660	-96,337	601,323	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	170,722	170,722	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,205,872	1,205,872	27,297	1,233,169	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,890,149	4,890,149	0	4,890,149	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,003,000	2,763,362	5,766,362	-54,832	5,711,530	5.00
6.00	00600	MAINTENANCE & REPAIRS	212,429	11,521	223,950	0	223,950	6.00
7.00	00700	OPERATION OF PLANT	0	570,970	570,970	62,625	633,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,748	44,748	0	44,748	8.00
9.00	00900	HOUSEKEEPING	201,700	178,535	380,235	0	380,235	9.00
10.00	01000	DIETARY	157,345	117,409	274,754	38,336	313,090	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	135,621	1,847	137,468	0	137,468	13.00
15.00	01500	PHARMACY	0	2,141,634	2,141,634	0	2,141,634	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	309,999	63,978	373,977	0	373,977	16.00
17.00	01700	SOCIAL SERVICE	21,146	16,534	37,680	0	37,680	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	543,266	543,266	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,038,067	576,683	1,614,750	18,971	1,633,721	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	590,578	811,936	1,402,514	-165,037	1,237,477	50.00
53.00	05300	ANESTHESIOLOGY	212,266	399,413	611,679	-552,356	59,323	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	437,300	141,361	578,661	-57,713	520,948	54.00
54.01	05401	ULTRASOUND	121,389	78,843	200,232	187	200,419	54.01
56.00	05600	RADIOISOTOPE	0	310,101	310,101	3,806	313,907	56.00
57.00	05700	CT SCAN	0	107,225	107,225	33,643	140,868	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	103,111	103,111	24,070	127,181	58.00
60.00	06000	LABORATORY	558,502	981,556	1,540,058	-14,295	1,525,763	60.00
65.00	06500	RESPIRATORY THERAPY	46,076	27,428	73,504	0	73,504	65.00
66.00	06600	PHYSICAL THERAPY	696,733	110,287	807,020	-25,032	781,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,763	3,476	39,239	10,302	49,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	113	113	135,643	135,756	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	316,468	316,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	136,715	136,715	0	136,715	75.01
75.02	03952	WOUND CENTER	0	155,675	155,675	0	155,675	75.02
76.00	03953	CARDIAC REHAB	77,919	1,798	79,717	0	79,717	76.00
76.01	03030	DIABETES EDUCATION	80,252	7,504	87,756	-38,336	49,420	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,978,757	1,574,039	6,552,796	-187,222	6,365,574	88.00
91.00	09100	EMERGENCY	747,292	1,183,923	1,931,215	-35,341	1,895,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	603,903	156,731	760,634	-35,211	725,423	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		38,390	38,390	-38,390	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,266,037	19,610,527	33,876,564	85,234	33,961,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	141,806	340,167	481,973	-82,504	399,469	194.00
194.01	07951	THE CENTER - FITNESS CENTER	65,104	13,492	78,596	-2,730	75,866	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,472,947	19,964,186	34,437,133	0	34,437,133	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-37,920	563,403		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	170,722		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-56,459	1,176,710		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-875,083	4,015,066		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-775,463	4,936,067		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	223,950		6.00
7.00	00700	OPERATION OF PLANT	0	633,595		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,748		8.00
9.00	00900	HOUSEKEEPING	0	380,235		9.00
10.00	01000	DIETARY	-42,908	270,182		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	137,468		13.00
15.00	01500	PHARMACY	-975,335	1,166,299		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-639	373,338		16.00
17.00	01700	SOCIAL SERVICE	0	37,680		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-543,266	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-15,500	1,618,221		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-226,614	1,010,863		50.00
53.00	05300	ANESTHESIOLOGY	0	59,323		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-3,744	517,204		54.00
54.01	05401	ULTRASOUND	0	200,419		54.01
56.00	05600	RADIOISOTOPE	0	313,907		56.00
57.00	05700	CT SCAN	0	140,868		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	127,181		58.00
60.00	06000	LABORATORY	0	1,525,763		60.00
65.00	06500	RESPIRATORY THERAPY	0	73,504		65.00
66.00	06600	PHYSICAL THERAPY	0	781,988		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	49,541		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-70	135,686		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	316,468		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	136,715		75.01
75.02	03952	WOUND CENTER	0	155,675		75.02
76.00	03953	CARDIAC REHAB	0	79,717		76.00
76.01	03030	DIABETES EDUCATION	0	49,420		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-6,819	6,358,755		88.00
91.00	09100	EMERGENCY	-437,221	1,458,653		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	725,423		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,997,041	29,964,757		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	399,469		194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	75,866		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,997,041	30,440,092		200.00

RECLASSIFICATIONS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 10/22/2018 2:07 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS COST OF SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	135,643	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	316,468	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	452,111	
	B - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,920	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	470	2.00
	0		0	38,390	
	C - TO RECLASS EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	14,295	0	1.00
	0		14,295	0	
	D - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP RELATED COST	3.00	0	63,762	1.00
	0		0	63,762	
	E - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,723	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	17,723	
	F - SURGERY-FREESTANDING CLINICS				
1.00	OPERATING ROOM	50.00	0	69,374	1.00
	TOTALS		0	69,374	
	G - TO RECLASS CRNA EXPENSES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	212,266	331,000	1.00
	0		212,266	331,000	
	H - TO RECLASS NORTHCAMPUS BLDG				
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	164,762	1.00
	0		0	164,762	
	I - TO RECLASS CT SCAN				
1.00	CT SCAN	57.00	33,643	0	1.00
	0		33,643	0	
	J - TO RECLASS RECRUITMENT EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	32,417	1.00
	0		0	32,417	
	K - TO RECLASS STRESS TEST SALARIES				
1.00	RADIOISOTOPE	56.00	3,806	0	1.00
2.00	ULTRASOUND	54.01	187	0	2.00
	0		3,993	0	
	L - TO RECLASS MRI SALARIES				
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	24,070	0	1.00
	0		24,070	0	
	M - TO RECLASS DIETARY SALARIES				
1.00	DIETARY	10.00	38,336	0	1.00
	0		38,336	0	
	O - UTILITY EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	62,625	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	62,625	
	P - HOME HEALTH BILLER				
1.00	ADMINISTRATIVE & GENERAL	5.00	23,154	0	1.00
	0		23,154	0	
	Q - RHC - HOSPITAL SUPPORT				
1.00	ADULTS & PEDIATRICS	30.00	35,000	0	1.00
2.00	OPERATING ROOM	50.00	0	157,240	2.00
	0		35,000	157,240	
500.00	Grand Total: Increases		384,757	1,389,404	500.00

RECLASSIFICATIONS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 10/22/2018 2:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES						
1.00	OPERATING ROOM	50.00	0	391,651	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	16,029	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	9,090	0		3.00
4.00	EMERGENCY	91.00	0	35,341	0		4.00
	0		0	452,111			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	38,390	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	38,390			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	14,295	0	0		1.00
	0		14,295	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,762	12		1.00
	0		0	63,762			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	1,128	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	10,211	0		2.00
3.00	FREESTANDING CLINICS	194.00	0	1,964	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	4,386	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	34	0		5.00
	0		0	17,723			
	F - SURGERY-FREESTANDING CLINICS						
1.00	FREESTANDING CLINICS	194.00	0	69,374	0		1.00
	TOTALS		0	69,374			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	212,266	331,000	0		1.00
	0		212,266	331,000			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	164,762	9		1.00
	0		0	164,762			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	33,643	0	0		1.00
	0		33,643	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,417	0		1.00
	0		0	32,417			
	K - TO RECLASS STRESS TEST SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	3,993	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,993	0			
	L - TO RECLASS MRI SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	24,070	0	0		1.00
	0		24,070	0			
	M - TO RECLASS DIETARY SALARIES						
1.00	DIABETES EDUCATION	76.01	38,336	0	0		1.00
	0		38,336	0			
	O - UTILITY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	23,904	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	17,188	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	7,671	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	11,166	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	2,696	0		5.00
	0		0	62,625			
	P - HOME HEALTH BILLER						
1.00	HOME HEALTH AGENCY	101.00	23,154	0	0		1.00
	0		23,154	0			
	Q - RHC - HOSPITAL SUPPORT						
1.00	RURAL HEALTH CLINIC	88.00	35,000	157,240	0		1.00
2.00		0.00	0	0	0		2.00
	0		35,000	157,240			
500.00	Grand Total: Decreases		384,757	1,389,404			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	326,334	0	0	0	0	1.00
2.00	Land Improvements	855,417	9,625	0	9,625	35,907	2.00
3.00	Buildings and Fixtures	17,042,609	460,593	0	460,593	514,218	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,152,472	700,877	0	700,877	407,128	6.00
7.00	HIT designated Assets	891,921	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,268,753	1,171,095	0	1,171,095	957,253	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,268,753	1,171,095	0	1,171,095	957,253	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	326,334	0	1.00
2.00	Land Improvements	829,135	0	2.00
3.00	Buildings and Fixtures	16,988,984	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,446,221	0	6.00
7.00	HIT designated Assets	891,921	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,482,595	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,482,595	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 10/22/2018 2:07 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	697,660	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,205,872	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,903,532	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	697,660		1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,205,872		2.00
3.00	Total (sum of lines 1-2)	0	1,903,532		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 10/22/2018 2:07 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	14,905,683	0	14,905,683	0.478417	30,505	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	2,912,435	0	2,912,435	0.093478	5,960	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,338,142	0	13,338,142	0.428105	27,297	2.00
3.00	Total (sum of lines 1-2)	31,156,260	0	31,156,260	1.000000	63,762	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	30,505	532,898	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	5,960	164,762	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	27,297	1,149,413	0	2.00
3.00	Total (sum of lines 1-2)	0	0	63,762	1,847,073	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	30,505	0	0	563,403	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	5,960	0	0	170,722	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	27,297	0	0	1,176,710	2.00
3.00	Total (sum of lines 1-2)	0	63,762	0	0	1,910,835	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 10/22/2018 2:07 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-37,920	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-470	ADMINISTRATIVE & GENERAL	5.00	11	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)	B	-19,567	ADMINISTRATIVE & GENERAL	5.00	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	-667,579			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	-42,908	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-70	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	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	-639	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-543,266	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 10/22/2018 2:07 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-53,126	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-8,816	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-45,515	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-3,370	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHYSICIAN RECRUITMENT COSTS	A	-1,947	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PERSONAL USE OF AUTO	A	-6,490	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-30,627	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING SALARY	A	-38,637	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-114,353	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-13,055	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	LOBBYING EXPENSES	A	-9,623	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SELF INSURANCE EXPENSE	A	-718,783	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	INSURANCE DIVIDEND	B	-500,953	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	RHC SELF INSURANCE EXPENSE	A	-112,618	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	USAC SUBSIDY	B	-24,797	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	EMPLOYEE ACTIVITIES	B	-925	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	340B CONTRACT DEPRECIATION	A	-3,333	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	340B CONTRACT EXPENSES	A	-975,335	PHARMACY	15.00	0	33.18
33.19	HOSPICE REVENUE	A	-15,500	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	PHYSICIAN ASSISTANT	B	-6,819	RURAL HEALTH CLINIC	88.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,997,041				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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 10/22/2018 2:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	35,000	0	35,000	0	0	1.00
2.00	91.00	EMERGENCY	1,041,422	437,221	604,201	0	0	2.00
3.00	50.00	OPERATING ROOM	69,374	69,374	0	0	0	3.00
4.00	75.01	SLEEP LAB	2,500	0	2,500	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	22,000	0	22,000	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	3,744	3,744	0	0	0	6.00
7.00	60.00	LABORATORY	19,500	0	19,500	0	0	7.00
8.00	50.00	OPERATING ROOM	157,240	157,240	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,350,780	667,579	683,201		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	75.01	SLEEP LAB	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	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	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	437,221		2.00
3.00	50.00	OPERATING ROOM	0	0	0	69,374		3.00
4.00	75.01	SLEEP LAB	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	3,744		6.00
7.00	60.00	LABORATORY	0	0	0	0		7.00
8.00	50.00	OPERATING ROOM	0	0	0	157,240		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	667,579		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/22/2018 2:07 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					27	1.00
2.00	Line 1 multiplied by 15 hours per week					405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	184.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.17	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)	37.09	37.09	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)					13,647	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)					13,647	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)					13,647	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)					74.17	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					30,039	22.00
23.00	Total salary equivalency (see instructions)					30,039	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/22/2018 2:07 pm

		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)	74.17	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)	30,039	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	30,039	63.00
64.00	Total cost of outside supplier services (from your records)	11,040	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	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	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	0	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	0	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	563,403	563,403				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	170,722	0	170,722			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,176,710			1,176,710		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,015,066	0	0	0	4,015,066	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,936,067	53,402	34,571	316,008	843,415	5.00
6.00	00600	MAINTENANCE & REPAIRS	223,950	26,709	0	1,169	59,971	6.00
7.00	00700	OPERATION OF PLANT	633,595	46,250	4,720	51,699	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,748	4,202	0	0	0	8.00
9.00	00900	HOUSEKEEPING	380,235	5,708	0	1,668	56,943	9.00
10.00	01000	DIETARY	270,182	13,139	0	6,206	55,243	10.00
11.00	01100	CAFETERIA	0	7,303	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	137,468	2,448	0	84	38,288	13.00
15.00	01500	PHARMACY	1,166,299	3,683	0	462	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	373,338	11,959	8,598	3,192	87,517	16.00
17.00	01700	SOCIAL SERVICE	37,680	0	0	0	5,970	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,618,221	53,043	0	34,842	302,941	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,010,863	49,519	0	78,842	166,728	50.00
53.00	05300	ANESTHESIOLOGY	59,323	702	0	259	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	517,204	9,894	0	99,773	107,162	54.00
54.01	05401	ULTRASOUND	200,419	2,862	0	62,820	34,322	54.01
56.00	05600	RADIOISOTOPE	313,907	2,296	0	0	1,074	56.00
57.00	05700	CT SCAN	140,868	2,886	0	113,322	9,498	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	127,181	7,399	0	215,516	6,795	58.00
60.00	06000	LABORATORY	1,525,763	14,343	0	23,344	153,637	60.00
65.00	06500	RESPIRATORY THERAPY	73,504	1,459	0	3,098	13,008	65.00
66.00	06600	PHYSICAL THERAPY	781,988	3,835	36,407	31,923	196,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,541	1,387	0	2,437	13,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,686	4,552	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	316,468	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	136,715	4,529	0	735	0	75.01
75.02	03952	WOUND CENTER	155,675	11,840	0	0	0	75.02
76.00	03953	CARDIAC REHAB	79,717	7,168	0	5,033	21,998	76.00
76.01	03030	DIABETES EDUCATION	49,420	1,507	0	0	11,833	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,358,755	112,254	51,524	39,539	1,395,684	88.00
91.00	09100	EMERGENCY	1,458,653	23,775	0	53,879	210,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	725,423	13,083	0	4,295	163,953	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,964,757	503,136	135,820	1,150,145	3,956,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,595	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	399,469	58,672	0	12,676	40,034	194.00
194.01	07951	THE CENTER - FITNESS CENTER	75,866	0	34,902	13,889	18,380	194.01
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)	30,440,092	563,403	170,722	1,176,710	4,015,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,183,463	6,183,463				5.00
6.00	00600	MAINTENANCE & REPAIRS	311,799	79,483	391,282			6.00
7.00	00700	OPERATION OF PLANT	736,264	187,687	29,763	953,714		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,950	12,478	2,704	8,135	72,267	8.00
9.00	00900	HOUSEKEEPING	444,554	113,325	3,674	11,052	0	9.00
10.00	01000	DIETARY	344,770	87,888	8,455	25,438	62	10.00
11.00	01100	CAFETERIA	7,303	1,862	4,700	14,139	0	11.00
13.00	01300	NURSING ADMINISTRATION	178,288	45,449	1,575	4,739	0	13.00
15.00	01500	PHARMACY	1,170,444	298,367	2,370	7,131	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	484,604	123,534	14,761	44,408	0	16.00
17.00	01700	SOCIAL SERVICE	43,650	11,127	0	0	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	2,009,047	512,142	34,134	102,692	16,821	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,305,952	332,911	31,867	95,870	12,563	50.00
53.00	05300	ANESTHESIOLOGY	60,284	15,367	452	1,358	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	734,033	187,118	6,367	19,155	4,890	54.00
54.01	05401	ULTRASOUND	300,423	76,583	1,842	5,541	4,134	54.01
56.00	05600	RADIOISOTOPE	317,277	80,880	1,478	4,445	0	56.00
57.00	05700	CT SCAN	266,574	67,955	1,857	5,588	4,276	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	356,891	90,978	4,761	14,324	2,543	58.00
60.00	06000	LABORATORY	1,717,087	437,716	9,230	27,768	0	60.00
65.00	06500	RESPIRATORY THERAPY	91,069	23,215	939	2,825	0	65.00
66.00	06600	PHYSICAL THERAPY	1,050,850	267,881	32,385	97,429	7,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,370	16,919	893	2,686	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,238	35,749	2,930	8,814	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	316,468	80,673	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	141,979	36,193	2,914	8,767	0	75.01
75.02	03952	WOUND CENTER	167,515	42,703	7,619	22,922	0	75.02
76.00	03953	CARDIAC REHAB	113,916	29,039	4,612	13,877	0	76.00
76.01	03030	DIABETES EDUCATION	62,760	15,999	970	2,917	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,957,756	2,028,587	86,847	127,373	401	88.00
91.00	09100	EMERGENCY	1,747,277	445,412	15,300	46,029	6,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	906,754	231,148	8,419	25,330	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,784,609	6,016,368	323,818	750,752	60,206	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,595	407	1,026	3,087	0	190.00
194.00	07950	FREESTANDING CLINICS	510,851	130,225	37,757	113,590	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	143,037	36,463	28,681	86,285	12,061	194.01
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)	30,440,092	6,183,463	391,282	953,714	72,267	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	572,605					9.00
10.00	01000	DIETARY	761	467,374				10.00
11.00	01100	CAFETERIA	19,777	330,911	378,692			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	29,578	259,629		13.00
15.00	01500	PHARMACY	2,757	0	22,143	0	1,503,212	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,805	0	88,248	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,587	136,463	72,571	100,329	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,201	0	46,225	87,020	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	12,537	0	17,779	0	0	54.00
54.01	05401	ULTRASOUND	6,778	0	1,940	0	0	54.01
56.00	05600	RADIOISOTOPE	2,222	0	970	0	0	56.00
57.00	05700	CT SCAN	6,900	0	6,303	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,778	0	0	58.00
60.00	06000	LABORATORY	12,496	0	37,659	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	815	0	10,829	4,051	0	65.00
66.00	06600	PHYSICAL THERAPY	13,575	0	323	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,503,212	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	4,537	0	0	0	0	75.01
75.02	03952	WOUND CENTER	6,520	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	4,917	0	2,101	0	0	76.00
76.01	03030	DIABETES EDUCATION	733	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	166,517	0	4,687	0	0	88.00
91.00	09100	EMERGENCY	74,231	0	33,295	68,229	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,907	0	1,455	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	512,573	467,374	377,884	259,629	1,503,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	29,584	0	808	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	30,448	0	0	0	0	194.01
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)	572,605	467,374	378,692	259,629	1,503,212	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	762,360					16.00
17.00	01700	SOCIAL SERVICE	0	54,777				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,961	54,777	0	3,161,524	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,587	0	0	2,066,196	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	77,461	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	17,914	0	0	999,793	0	54.00
54.01	05401	ULTRASOUND	3,789	0	0	401,030	0	54.01
56.00	05600	RADIOISOTOPE	3,100	0	0	410,372	0	56.00
57.00	05700	CT SCAN	4,134	0	0	363,587	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,411	0	0	473,686	0	58.00
60.00	06000	LABORATORY	26,870	0	0	2,268,826	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,301	0	0	143,044	0	65.00
66.00	06600	PHYSICAL THERAPY	689	0	0	1,471,083	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	86,868	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	187,731	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	397,141	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,503,212	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	11,024	0	0	205,414	0	75.01
75.02	03952	WOUND CENTER	4,134	0	0	251,413	0	75.02
76.00	03953	CARDIAC REHAB	4,134	0	0	172,596	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	83,379	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	444,051	0	0	10,816,219	0	88.00
91.00	09100	EMERGENCY	96,802	0	0	2,533,140	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	0	0	1,176,013	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	737,901	54,777	0	29,249,728	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	6,115	0	190.00
194.00	07950	FREESTANDING CLINICS	24,459	0	0	847,274	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	336,975	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	762,360	54,777	0	30,440,092	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
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	3,161,524		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,066,196		50.00
53.00	05300	ANESTHESIOLOGY	77,461		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	999,793		54.00
54.01	05401	ULTRASOUND	401,030		54.01
56.00	05600	RADIOISOTOPE	410,372		56.00
57.00	05700	CT SCAN	363,587		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	473,686		58.00
60.00	06000	LABORATORY	2,268,826		60.00
65.00	06500	RESPIRATORY THERAPY	143,044		65.00
66.00	06600	PHYSICAL THERAPY	1,471,083		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	86,868		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	187,731		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	397,141		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,212		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	205,414		75.01
75.02	03952	WOUND CENTER	251,413		75.02
76.00	03953	CARDIAC REHAB	172,596		76.00
76.01	03030	DIABETES EDUCATION	83,379		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	10,816,219		88.00
91.00	09100	EMERGENCY	2,533,140		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	1,176,013		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,249,728		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,115		190.00
194.00	07950	FREESTANDING CLINICS	847,274		194.00
194.01	07951	THE CENTER - FITNESS CENTER	336,975		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	30,440,092		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	CAPITAL RELATED COSTS Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	123,816	53,402	34,571	316,008	527,797	5.00
6.00	00600	MAINTENANCE & REPAIRS	492	26,709	0	1,169	28,370	6.00
7.00	00700	OPERATION OF PLANT	0	46,250	4,720	51,699	102,669	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,202	0	0	4,202	8.00
9.00	00900	HOUSEKEEPING	0	5,708	0	1,668	7,376	9.00
10.00	01000	DIETARY	0	13,139	0	6,206	19,345	10.00
11.00	01100	CAFETERIA	0	7,303	0	0	7,303	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,448	0	84	2,532	13.00
15.00	01500	PHARMACY	6,534	3,683	0	462	10,679	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,959	8,598	3,192	23,749	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,618	53,043	0	34,842	109,503	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,654	49,519	0	78,842	181,015	50.00
53.00	05300	ANESTHESIOLOGY	0	702	0	259	961	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	9,894	0	99,773	109,667	54.00
54.01	05401	ULTRASOUND	0	2,862	0	62,820	65,682	54.01
56.00	05600	RADIOISOTOPE	0	2,296	0	0	2,296	56.00
57.00	05700	CT SCAN	0	2,886	0	113,322	116,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,399	0	215,516	222,915	58.00
60.00	06000	LABORATORY	0	14,343	0	23,344	37,687	60.00
65.00	06500	RESPIRATORY THERAPY	12,852	1,459	0	3,098	17,409	65.00
66.00	06600	PHYSICAL THERAPY	0	3,835	36,407	31,923	72,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,387	0	2,437	3,824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,552	0	0	4,552	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	4,529	0	735	5,264	75.01
75.02	03952	WOUND CENTER	0	11,840	0	0	11,840	75.02
76.00	03953	CARDIAC REHAB	0	7,168	0	5,033	12,201	76.00
76.01	03030	DIABETES EDUCATION	0	1,507	0	0	1,507	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,737	112,254	51,524	39,539	218,054	88.00
91.00	09100	EMERGENCY	8,814	23,775	0	53,879	86,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13,083	0	4,295	17,378	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,517	503,136	135,820	1,150,145	2,030,618	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,595	0	0	1,595	190.00
194.00	07950	FREESTANDING CLINICS	0	58,672	0	12,676	71,348	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	34,902	13,889	48,791	194.01
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)	241,517	563,403	170,722	1,176,710	2,152,352	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	527,797				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,784	35,154			6.00
7.00	00700	OPERATION OF PLANT	0	16,020	2,674	121,363		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,065	243	1,035	6,545	8.00
9.00	00900	HOUSEKEEPING	0	9,673	330	1,406	0	9.00
10.00	01000	DIETARY	0	7,502	760	3,237	6	10.00
11.00	01100	CAFETERIA	0	159	422	1,799	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,879	142	603	0	13.00
15.00	01500	PHARMACY	0	25,468	213	907	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,544	1,326	5,651	0	16.00
17.00	01700	SOCIAL SERVICE	0	950	0	0	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	43,715	3,067	13,068	1,524	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,416	2,863	12,200	1,138	50.00
53.00	05300	ANESTHESIOLOGY	0	1,312	41	173	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	15,972	572	2,438	443	54.00
54.01	05401	ULTRASOUND	0	6,537	165	705	374	54.01
56.00	05600	RADIOISOTOPE	0	6,904	133	566	0	56.00
57.00	05700	CT SCAN	0	5,800	167	711	387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,766	428	1,823	230	58.00
60.00	06000	LABORATORY	0	37,362	829	3,534	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,982	84	359	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,865	2,910	12,398	720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,444	80	342	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,051	263	1,122	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,886	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	3,089	262	1,116	0	75.01
75.02	03952	WOUND CENTER	0	3,645	685	2,917	0	75.02
76.00	03953	CARDIAC REHAB	0	2,479	414	1,766	0	76.00
76.01	03030	DIABETES EDUCATION	0	1,366	87	371	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	173,150	7,802	16,208	36	88.00
91.00	09100	EMERGENCY	0	38,019	1,375	5,857	595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	19,730	756	3,223	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	513,534	29,093	95,535	5,453	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	35	92	393	0	190.00
194.00	07950	FREESTANDING CLINICS	0	11,116	3,392	14,455	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	3,112	2,577	10,980	1,092	194.01
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)	0	527,797	35,154	121,363	6,545	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	18,785					9.00
10.00	01000	DIETARY	25	30,875				10.00
11.00	01100	CAFETERIA	649	21,860	32,192			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,514	9,670		13.00
15.00	01500	PHARMACY	90	0	1,882	0	39,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223	0	7,503	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,709	9,015	6,169	3,737	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,762	0	3,930	3,241	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	411	0	1,511	0	0	54.00
54.01	05401	ULTRASOUND	222	0	165	0	0	54.01
56.00	05600	RADIOISOTOPE	73	0	82	0	0	56.00
57.00	05700	CT SCAN	226	0	536	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	151	0	0	58.00
60.00	06000	LABORATORY	410	0	3,201	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	27	0	921	151	0	65.00
66.00	06600	PHYSICAL THERAPY	445	0	27	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	39,239	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	149	0	0	0	0	75.01
75.02	03952	WOUND CENTER	214	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	161	0	179	0	0	76.00
76.01	03030	DIABETES EDUCATION	24	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,465	0	398	0	0	88.00
91.00	09100	EMERGENCY	2,435	0	2,830	2,541	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	95	0	124	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,815	30,875	32,123	9,670	39,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	971	0	69	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	999	0	0	0	0	194.01
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)	18,785	30,875	32,192	9,670	39,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,996					16.00
17.00	01700	SOCIAL SERVICE	0	950				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,568	950		196,025	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,472	0		240,037	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,487	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,151	0		132,165	0	54.00
54.01	05401	ULTRASOUND	244	0		74,094	0	54.01
56.00	05600	RADIOISOTOPE	199	0		10,253	0	56.00
57.00	05700	CT SCAN	266	0		124,301	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	155	0		233,468	0	58.00
60.00	06000	LABORATORY	1,727	0		84,750	0	60.00
65.00	06500	RESPIRATORY THERAPY	598	0		21,531	0	65.00
66.00	06600	PHYSICAL THERAPY	44	0		111,574	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		5,690	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		8,988	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		6,886	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		39,239	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	708	0		10,588	0	75.01
75.02	03952	WOUND CENTER	266	0		19,567	0	75.02
76.00	03953	CARDIAC REHAB	266	0		17,466	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		3,355	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,539	0		449,652	0	88.00
91.00	09100	EMERGENCY	6,221	0		146,341	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	0		41,306	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,424	950	0	1,979,763	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		2,115	0	190.00
194.00	07950	FREESTANDING CLINICS	1,572	0		102,923	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		67,551	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,996	950	0	2,152,352	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
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	196,025		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	240,037		50.00
53.00	05300	ANESTHESIOLOGY	2,487		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	132,165		54.00
54.01	05401	ULTRASOUND	74,094		54.01
56.00	05600	RADIOISOTOPE	10,253		56.00
57.00	05700	CT SCAN	124,301		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	233,468		58.00
60.00	06000	LABORATORY	84,750		60.00
65.00	06500	RESPIRATORY THERAPY	21,531		65.00
66.00	06600	PHYSICAL THERAPY	111,574		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,690		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,988		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,886		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,239		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	10,588		75.01
75.02	03952	WOUND CENTER	19,567		75.02
76.00	03953	CARDIAC REHAB	17,466		76.00
76.01	03030	DIABETES EDUCATION	3,355		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	449,652		88.00
91.00	09100	EMERGENCY	146,341		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	41,306		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,979,763		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,115		190.00
194.00	07950	FREESTANDING CLINICS	102,923		194.00
194.01	07951	THE CENTER - FITNESS CENTER	67,551		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,152,352		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			1,149,412			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	14,222,044		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,698	5,537	308,679	2,987,517	-6,183,463	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	1,142	212,429	0	6.00
7.00	00700	OPERATION OF PLANT	5,801	756	50,500	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	1,629	201,700	0	9.00
10.00	01000	DIETARY	1,648	0	6,062	195,681	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	82	135,621	0	13.00
15.00	01500	PHARMACY	462	0	451	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	3,118	309,999	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	21,146	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653	0	34,034	1,073,067	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	0	77,013	590,578	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	253	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	97,458	379,587	0	54.00
54.01	05401	ULTRASOUND	359	0	61,363	121,576	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	3,806	0	56.00
57.00	05700	CT SCAN	362	0	110,693	33,643	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	210,516	24,070	0	58.00
60.00	06000	LABORATORY	1,799	0	22,802	544,207	0	60.00
65.00	06500	RESPIRATORY THERAPY	183	0	3,026	46,076	0	65.00
66.00	06600	PHYSICAL THERAPY	481	5,831	31,182	696,733	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	174	0	2,380	46,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	568	0	718	0	0	75.01
75.02	03952	WOUND CENTER	1,485	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	899	0	4,916	77,919	0	76.00
76.01	03030	DIABETES EDUCATION	189	0	0	41,916	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	38,622	4,943,757	0	88.00
91.00	09100	EMERGENCY	2,982	0	52,629	747,292	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,641	0	4,195	580,749	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,107	21,753	1,123,463	14,015,134	-6,183,463	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	7,359	0	12,382	141,806	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	5,590	13,567	65,104	0	194.01
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)	563,403	170,722	1,176,710	4,015,066		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.972759	6.243719	1.023750	0.282313		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,256,629					5.00
6.00	00600	MAINTENANCE & REPAIRS	311,799	76,263				6.00
7.00	00700	OPERATION OF PLANT	736,264	5,801	61,787			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,950	527	527	18,724		8.00
9.00	00900	HOUSEKEEPING	444,554	716	716	0	210,780	9.00
10.00	01000	DIETARY	344,770	1,648	1,648	16	280	10.00
11.00	01100	CAFETERIA	7,303	916	916	0	7,280	11.00
13.00	01300	NURSING ADMINISTRATION	178,288	307	307	0	0	13.00
15.00	01500	PHARMACY	1,170,444	462	462	0	1,015	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	484,604	2,877	2,877	0	2,505	16.00
17.00	01700	SOCIAL SERVICE	43,650	0	0	0	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	2,009,047	6,653	6,653	4,358	30,401	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,305,952	6,211	6,211	3,255	30,995	50.00
53.00	05300	ANESTHESIOLOGY	60,284	88	88	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	734,033	1,241	1,241	1,267	4,615	54.00
54.01	05401	ULTRASOUND	300,423	359	359	1,071	2,495	54.01
56.00	05600	RADIOISOTOPE	317,277	288	288	0	818	56.00
57.00	05700	CT SCAN	266,574	362	362	1,108	2,540	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	356,891	928	928	659	0	58.00
60.00	06000	LABORATORY	1,717,087	1,799	1,799	0	4,600	60.00
65.00	06500	RESPIRATORY THERAPY	91,069	183	183	0	300	65.00
66.00	06600	PHYSICAL THERAPY	1,050,850	6,312	6,312	2,060	4,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,370	174	174	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,238	571	571	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	316,468	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	141,979	568	568	0	1,670	75.01
75.02	03952	WOUND CENTER	167,515	1,485	1,485	0	2,400	75.02
76.00	03953	CARDIAC REHAB	113,916	899	899	0	1,810	76.00
76.01	03030	DIABETES EDUCATION	62,760	189	189	0	270	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,957,756	16,927	8,252	104	61,296	88.00
91.00	09100	EMERGENCY	1,747,277	2,982	2,982	1,701	27,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	906,754	1,641	1,641	0	1,070	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,601,146	63,114	48,638	15,599	188,682	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,595	200	200	0	0	190.00
194.00	07950	FREESTANDING CLINICS	510,851	7,359	7,359	0	10,890	194.00
194.01	07951	THE CENTER - FITNESS CENTER	143,037	5,590	5,590	3,125	11,208	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,183,463	391,282	953,714	72,267	572,605	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.254918	5.130692	15.435512	3.859592	2.716600	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	527,797	35,154	121,363	6,545	18,785	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.021759	0.460957	1.964216	0.349551	0.089121	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	28,259					10.00
11.00	01100	CAFETERIA	20,008	2,343				11.00
13.00	01300	NURSING ADMINISTRATION	0	183	113,694			13.00
15.00	01500	PHARMACY	0	137	0	2,141,634		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	546	0	0	2,213	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,251	449	43,935	0	116	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	286	38,107	0	202	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	110	0	0	52	54.00
54.01	05401	ULTRASOUND	0	12	0	0	11	54.01
56.00	05600	RADIOISOTOPE	0	6	0	0	9	56.00
57.00	05700	CT SCAN	0	39	0	0	12	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11	0	0	7	58.00
60.00	06000	LABORATORY	0	233	0	0	78	60.00
65.00	06500	RESPIRATORY THERAPY	0	67	1,774	0	27	65.00
66.00	06600	PHYSICAL THERAPY	0	2	0	0	2	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,141,634	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	32	75.01
75.02	03952	WOUND CENTER	0	0	0	0	12	75.02
76.00	03953	CARDIAC REHAB	0	13	0	0	12	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	29	0	0	1,289	88.00
91.00	09100	EMERGENCY	0	206	29,878	0	281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,259	2,338	113,694	2,141,634	2,142	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	5	0	0	71	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	0	0	194.01
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)	467,374	378,692	259,629	1,503,212	762,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.538943	161.626974	2.283577	0.701900	344.491640	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,875	32,192	9,670	39,239	48,996	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.092572	13.739650	0.085053	0.018322	22.140081	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 10/22/2018 2:07 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,330			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,330	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,330	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	0		194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		194.01
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)	54,777	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.185714	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	950	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.714286	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,161,524		3,161,524	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,066,196		2,066,196	0	0	50.00
53.00	05300	ANESTHESIOLOGY	77,461		77,461	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	999,793		999,793	0	0	54.00
54.01	05401	ULTRASOUND	401,030		401,030	0	0	54.01
56.00	05600	RADIOISOTOPE	410,372		410,372	0	0	56.00
57.00	05700	CT SCAN	363,587		363,587	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	473,686		473,686	0	0	58.00
60.00	06000	LABORATORY	2,268,826		2,268,826	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	143,044	0	143,044	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,471,083	0	1,471,083	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86,868		86,868	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	187,731		187,731	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	397,141		397,141	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,212		1,503,212	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	205,414		205,414	0	0	75.01
75.02	03952	WOUND CENTER	251,413		251,413	0	0	75.02
76.00	03953	CARDIAC REHAB	172,596		172,596	0	0	76.00
76.01	03030	DIABETES EDUCATION	83,379		83,379	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,816,219		10,816,219	0	0	88.00
91.00	09100	EMERGENCY	2,533,140		2,533,140	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	513,301		513,301		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,176,013		1,176,013		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,763,029	0	29,763,029	0	0	200.00
201.00		Less Observation Beds	513,301		513,301		0	201.00
202.00		Total (see instructions)	29,249,728	0	29,249,728	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,203,798		1,203,798			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	544,388	5,056,969	5,601,357	0.368874	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	30,601	140,416	171,017	0.452943	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	125,965	2,898,468	3,024,433	0.330572	0.000000	54.00
54.01	05401	ULTRASOUND	231,421	4,039,611	4,271,032	0.093895	0.000000	54.01
56.00	05600	RADIOISOTOPE	37,019	1,590,327	1,627,346	0.252173	0.000000	56.00
57.00	05700	CT SCAN	385,856	12,574,437	12,960,293	0.028054	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,000	2,833,733	2,870,733	0.165005	0.000000	58.00
60.00	06000	LABORATORY	843,752	11,291,728	12,135,480	0.186958	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	52,983	358,824	411,807	0.347357	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	537,657	4,886,590	5,424,247	0.271205	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	34,794	492,961	527,755	0.164599	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,714	950,331	1,135,045	0.165395	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	216,884	388,623	605,507	0.655882	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,310	2,797,843	3,159,153	0.475828	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	2,531	811,972	814,503	0.252196	0.000000	75.01
75.02	03952	WOUND CENTER	0	448,758	448,758	0.560242	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	213,246	213,246	0.809375	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0	37,341	37,341	2.232908	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,173,095	7,173,095			88.00
91.00	09100	EMERGENCY	67,882	7,135,389	7,203,271	0.351665	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,467	269,036	273,503	1.876766	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,845,636	1,845,636			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,903,022	68,235,334	73,138,356			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,903,022	68,235,334	73,138,356			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		75.00
75.01	03951	SLEEP LAB	0.000000		75.01
75.02	03952	WOUND CENTER	0.000000		75.02
76.00	03953	CARDIAC REHAB	0.000000		76.00
76.01	03030	DIABETES EDUCATION	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			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			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	240,037	5,601,357	0.042853	222,957	9,554	50.00
53.00	05300	ANESTHESIOLOGY	2,487	171,017	0.014542	10,787	157	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	132,165	3,024,433	0.043699	75,861	3,315	54.00
54.01	05401	ULTRASOUND	74,094	4,271,032	0.017348	149,694	2,597	54.01
56.00	05600	RADIOISOTOPE	10,253	1,627,346	0.006300	8,251	52	56.00
57.00	05700	CT SCAN	124,301	12,960,293	0.009591	242,960	2,330	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	233,468	2,870,733	0.081327	25,913	2,107	58.00
60.00	06000	LABORATORY	84,750	12,135,480	0.006984	482,926	3,373	60.00
65.00	06500	RESPIRATORY THERAPY	21,531	411,807	0.052284	29,291	1,531	65.00
66.00	06600	PHYSICAL THERAPY	111,574	5,424,247	0.020569	144,352	2,969	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,690	527,755	0.010782	24,154	260	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,988	1,135,045	0.007919	74,815	592	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,886	605,507	0.011372	131,027	1,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,239	3,159,153	0.012421	156,009	1,938	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	10,588	814,503	0.012999	2,430	32	75.01
75.02	03952	WOUND CENTER	19,567	448,758	0.043603	0	0	75.02
76.00	03953	CARDIAC REHAB	17,466	213,246	0.081905	0	0	76.00
76.01	03030	DIABETES EDUCATION	3,355	37,341	0.089848	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	449,652	7,173,095	0.062686	0	0	88.00
91.00	09100	EMERGENCY	146,341	7,203,271	0.020316	2,184	44	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,826	273,503	0.116364	394	46	92.00
200.00		Total (lines 50 through 199)	1,774,258	70,088,922		1,784,005	32,387	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,601,357	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	171,017	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	3,024,433	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,271,032	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,627,346	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	12,960,293	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,870,733	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,135,480	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	411,807	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,424,247	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	527,755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,135,045	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	605,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,159,153	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	75.00
75.01	03951	SLEEP LAB	0	0	0	814,503	0.000000	75.01
75.02	03952	WOUND CENTER	0	0	0	448,758	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	0	0	213,246	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	37,341	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,173,095	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	7,203,271	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	273,503	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	70,088,922		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	222,957	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,787	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	75,861	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	149,694	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	8,251	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	242,960	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	25,913	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	482,926	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	29,291	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	144,352	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	24,154	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	74,815	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	131,027	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	156,009	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.000000	2,430	0	0	0	75.01
75.02	03952	WOUND CENTER	0.000000	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	2,184	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	394	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,784,005	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.368874	0	2,007,985	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.452943	0	36,179	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.330572	0	853,565	0	0	54.00
54.01	05401	ULTRASOUND	0.093895	0	1,634,919	0	0	54.01
56.00	05600	RADIOISOTOPE	0.252173	0	812,088	0	0	56.00
57.00	05700	CT SCAN	0.028054	0	4,975,427	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.165005	0	1,093,772	0	0	58.00
60.00	06000	LABORATORY	0.186958	0	4,371,534	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.347357	0	167,359	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.271205	0	1,923,455	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164599	0	223,350	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165395	0	296,749	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.655882	0	163,168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475828	0	2,025,289	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.252196	0	330,620	0	0	75.01
75.02	03952	WOUND CENTER	0.560242	0	288,622	0	0	75.02
76.00	03953	CARDIAC REHAB	0.809375	0	132,338	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.232908	0	10,139	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.351665	0	1,906,388	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.876766	0	143,084	0	0	92.00
200.00		Subtotal (see instructions)		0	23,396,030	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	23,396,030	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	740,693	0		50.00
53.00	05300	ANESTHESIOLOGY	16,387	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	282,165	0		54.00
54.01	05401	ULTRASOUND	153,511	0		54.01
56.00	05600	RADIOISOTOPE	204,787	0		56.00
57.00	05700	CT SCAN	139,581	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	180,478	0		58.00
60.00	06000	LABORATORY	817,293	0		60.00
65.00	06500	RESPIRATORY THERAPY	58,133	0		65.00
66.00	06600	PHYSICAL THERAPY	521,651	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	36,763	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,081	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	107,019	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,689	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	83,381	0		75.01
75.02	03952	WOUND CENTER	161,698	0		75.02
76.00	03953	CARDIAC REHAB	107,111	0		76.00
76.01	03030	DIABETES EDUCATION	22,639	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	670,410	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	268,535	0		92.00
200.00		Subtotal (see instructions)	5,585,005	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,585,005	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.368874	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.452943	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.330572	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.093895	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.252173	0	0	0	0	56.00
57.00	05700	CT SCAN	0.028054	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.165005	0	0	0	0	58.00
60.00	06000	LABORATORY	0.186958	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.347357	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.271205	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164599	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165395	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.655882	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475828	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.252196	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.560242	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0.809375	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.232908	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.351665	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.876766	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: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
76.01	03030	DIABETES EDUCATION	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,367	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,712	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)	1,330	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	639	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	840	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	565	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	152.66	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	152.66	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,161,524	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)	1,221	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)	1,221	25.00
26.00	Total swing-bed cost (see instructions)	861,079	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,300,445	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,300,445	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)	1,343.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,128,725	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,128,725	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	457,687	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,586,412	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	759,202	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	759,202	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)	382	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,343.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	513,301	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	196,025	3,161,524	0.062003	513,301	31,826	90.00
91.00	Nursing School cost	0	3,161,524	0.000000	513,301	0	91.00
92.00	Allied health cost	0	3,161,524	0.000000	513,301	0	92.00
93.00	All other Medical Education	0	3,161,524	0.000000	513,301	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		420,000		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.368874	222,957	82,243	50.00
53.00	05300	ANESTHESIOLOGY	0.452943	10,787	4,886	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.330572	75,861	25,078	54.00
54.01	05401	ULTRASOUND	0.093895	149,694	14,056	54.01
56.00	05600	RADIOISOTOPE	0.252173	8,251	2,081	56.00
57.00	05700	CT SCAN	0.028054	242,960	6,816	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.165005	25,913	4,276	58.00
60.00	06000	LABORATORY	0.186958	482,926	90,287	60.00
65.00	06500	RESPIRATORY THERAPY	0.347357	29,291	10,174	65.00
66.00	06600	PHYSICAL THERAPY	0.271205	144,352	39,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164599	24,154	3,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165395	74,815	12,374	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.655882	131,027	85,938	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475828	156,009	74,233	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.252196	2,430	613	75.01
75.02	03952	WOUND CENTER	0.560242	0	0	75.02
76.00	03953	CARDIAC REHAB	0.809375	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.232908	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.351665	2,184	768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.876766	394	739	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,784,005	457,687	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,784,005		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.368874	6,203	2,288	50.00
53.00	05300	ANESTHESIOLOGY	0.452943	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.330572	17,681	5,845	54.00
54.01	05401	ULTRASOUND	0.093895	18,584	1,745	54.01
56.00	05600	RADIOISOTOPE	0.252173	0	0	56.00
57.00	05700	CT SCAN	0.028054	25,329	711	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.165005	2,601	429	58.00
60.00	06000	LABORATORY	0.186958	116,909	21,857	60.00
65.00	06500	RESPIRATORY THERAPY	0.347357	11,670	4,054	65.00
66.00	06600	PHYSICAL THERAPY	0.271205	304,521	82,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164599	2,432	400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165395	16,313	2,698	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.655882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.475828	94,987	45,197	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.252196	101	25	75.01
75.02	03952	WOUND CENTER	0.560242	0	0	75.02
76.00	03953	CARDIAC REHAB	0.809375	0	0	76.00
76.01	03030	DIABETES EDUCATION	2.232908	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.351665	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.876766	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		617,331	167,837	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		617,331		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 10/22/2018 2:07 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,585,005	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)	5,585,005	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)	5,640,855	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 (for CAH, see instructions)	51,778	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,775,907	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)	1,813,170	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)	1,813,170	30.00
31.00	Primary payer payments	276	31.00
32.00	Subtotal (line 30 minus line 31)	1,812,894	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)	578,024	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	375,716	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	338,293	36.00
37.00	Subtotal (see instructions)	2,188,610	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)	2,188,610	40.00
40.01	Sequestration adjustment (see instructions)	43,772	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,256,634	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-111,796	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,295,337		2,447,305	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	01/11/2018	20,428		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	01/11/2018	190,671	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)		20,428		-190,671	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)		1,315,765		2,256,634	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		16,862		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		111,796	6.02
7.00	Total Medicare program liability (see instructions)		1,332,627		2,144,838	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: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		796,948		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	01/11/2018	15,226		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		15,226		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)		812,174		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		98,725		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		910,899		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 10/22/2018 2:07 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1349 | Component CCN: 14-Z349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 10/22/2018 2:07 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	766,794	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)	169,515	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	565	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)	936,309	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	936,309	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)	936,309	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,820	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)	929,489	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)	929,489	0	19.00
19.01	Sequestration adjustment (see instructions)	18,590	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	812,174	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)	98,725	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: 14-1349	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 10/22/2018 2:07 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,586,412	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)	1,586,412	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,602,276	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)	1,602,276	19.00
20.00	Deductibles (exclude professional component)	265,590	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,336,686	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,336,686	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,596	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,137	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,996	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,359,823	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)	1,359,823	30.00
30.01	Sequestration adjustment (see instructions)	27,196	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,315,765	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)	16,862	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: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 10/22/2018 2:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,504,634	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	8,886,910	0	0	0	4.00
5.00	Other receivable	204,992	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,600,000	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,399,918	0	0	0	8.00
9.00	Other current assets	622,470	0	0	0	9.00
10.00	Due from other funds	423,723	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,442,647	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	326,334	0	0	0	12.00
13.00	Land improvements	829,135	0	0	0	13.00
14.00	Accumulated depreciation	-671,168	0	0	0	14.00
15.00	Buildings	16,960,323	0	0	0	15.00
16.00	Accumulated depreciation	-12,388,464	0	0	0	16.00
17.00	Leasehold improvements	28,661	0	0	0	17.00
18.00	Accumulated depreciation	-20,653	0	0	0	18.00
19.00	Fixed equipment	23,015	0	0	0	19.00
20.00	Accumulated depreciation	-22,546	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	13,311,854	0	0	0	23.00
24.00	Accumulated depreciation	-10,523,384	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	245,179	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,098,286	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,325,718	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,325,718	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,866,651	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,020,494	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,208,945	0	0	0	38.00
39.00	Payroll taxes payable	1,876,235	0	0	0	39.00
40.00	Notes and loans payable (short term)	495,146	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)	4,600,820	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,834,992	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)	1,834,992	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,435,812	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,430,839				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)	25,430,839	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,866,651	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 10/22/2018 2:07 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,379,960		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,050,879				2.00
3.00	Total (sum of line 1 and line 2)		25,430,839		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)		25,430,839		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,430,839		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/22/2018 2:07 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,391,553		1,391,553	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	86,256		86,256	5.00
6.00	Swing bed - NF	2,240		2,240	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)	1,480,049		1,480,049	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)	1,480,049		1,480,049	17.00
18.00	Ancillary services	3,649,270	52,580,022	56,229,292	18.00
19.00	Outpatient services	72,349	7,404,425	7,476,774	19.00
20.00	RURAL HEALTH CLINIC	0	7,173,095	7,173,095	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,845,636	1,845,636	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	63,129	1,200,577	1,263,706	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,264,797	70,203,755	75,468,552	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,437,133		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)		34,437,133		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1349 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 10/22/2018 2:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,468,552	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,156,182	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,312,370	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,437,133	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,124,763	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	155,173	6.00
7.00	Income from investments	415,942	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	42,908	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	639	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	188,731	22.00
23.00	Governmental appropriations	248,086	23.00
24.00	OTHER MISC REVENUE	943,390	24.00
24.01	340B CONTRACT PHARMACY REVENUE	2,180,773	24.01
25.00	Total other income (sum of lines 6-24)	4,175,642	25.00
26.00	Total (line 5 plus line 25)	3,050,879	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,050,879	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H | Date/Time Prepared: 10/22/2018 2:07 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	22,761	22,761	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	266,696	0	0	0	127,760	394,456	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	216,145	0	0	0	0	216,145	6.00
7.00	Physical Therapy	120,913	0	0	0	0	120,913	7.00
8.00	Occupational Therapy	0	0	0	60	0	60	8.00
9.00	Speech Pathology	0	0	0	6,150	0	6,150	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	149	0	0	0	0	149	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	603,903	0	0	6,210	150,521	760,634	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	-7,671	15,090	0	15,090			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-27,540	366,916	0	366,916			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	216,145	0	216,145			6.00
7.00	Physical Therapy	0	120,913	0	120,913			7.00
8.00	Occupational Therapy	0	60	0	60			8.00
9.00	Speech Pathology	0	6,150	0	6,150			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	149	0	149			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-35,211	725,423	0	725,423			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: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	15,090	0	0	15,090		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	366,916	0	0	15,090	0	382,006	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	216,145	0	0	0	0	216,145	6.00
7.00	Physical Therapy	120,913	0	0	0	0	120,913	7.00
8.00	Occupational Therapy	60	0	0	0	0	60	8.00
9.00	Speech Pathology	6,150	0	0	0	0	6,150	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	149	0	0	0	0	149	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	725,423	0	0	15,090	0	725,423	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	382,006			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	240,432	456,577		6.00
7.00	Physical Therapy	134,500	255,413		7.00
8.00	Occupational Therapy	67	127		8.00
9.00	Speech Pathology	6,841	12,991		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	166	315		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		725,423		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 10/22/2018 2:07 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	1,641		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	1,641	0	-382,006	343,417	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	216,145	6.00
7.00	Physical Therapy	0	0	0	0	0	120,913	7.00
8.00	Occupational Therapy	0	0	0	0	0	60	8.00
9.00	Speech Pathology	0	0	0	0	0	6,150	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	149	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-382,006	343,417	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	15,090	0		382,006	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	9.195612	0.000000		1.112368	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	13,083	0	4,295	68,755	86,133	1.00
2.00	Skilled Nursing Care	456,577	0	0	0	61,021	517,598	2.00
3.00	Physical Therapy	255,413	0	0	0	34,135	289,548	3.00
4.00	Occupational Therapy	127	0	0	0	0	127	4.00
5.00	Speech Pathology	12,991	0	0	0	0	12,991	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	315	0	0	0	42	357	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	725,423	13,083	0	4,295	163,953	906,754	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	21,957	8,419	25,330	0	2,907	0	1.00
2.00	Skilled Nursing Care	131,945	0	0	0	0	0	2.00
3.00	Physical Therapy	73,811	0	0	0	0	0	3.00
4.00	Occupational Therapy	32	0	0	0	0	0	4.00
5.00	Speech Pathology	3,312	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	91	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	231,148	8,419	25,330	0	2,907	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

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	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	1,455	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,455	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	146,201	0	146,201				1.00
2.00	Skilled Nursing Care	649,543	0	649,543	92,213	741,756		2.00
3.00	Physical Therapy	363,359	0	363,359	51,586	414,945		3.00
4.00	Occupational Therapy	159	0	159	23	182		4.00
5.00	Speech Pathology	16,303	0	16,303	2,315	18,618		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	448	0	448	64	512		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,176,013	0	1,176,013	146,201	1,176,013		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.				0.141969			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: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-2 Part II | Date/Time Prepared: 10/22/2018 2:07 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,641	0	4,195	243,542	0	86,133	1.00
2.00	Skilled Nursing Care	0	0	0	216,145	0	517,598	2.00
3.00	Physical Therapy	0	0	0	120,913	0	289,548	3.00
4.00	Occupational Therapy	0	0	0	0	0	127	4.00
5.00	Speech Pathology	0	0	0	0	0	12,991	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	149	0	357	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	0	4,195	580,749		906,754	20.00
21.00	Total cost to be allocated	13,083	0	4,295	163,953		231,148	21.00
22.00	Unit cost multiplier	7.972578	0.000000	1.023838	0.282313		0.254918	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	1,641	0	1,070	0	9	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	1,641	0	1,070	0	9	20.00
21.00	Total cost to be allocated	8,419	25,330	0	2,907	0	1,455	21.00
22.00	Unit cost multiplier	5.130408	15.435710	0.000000	2.716822	0.000000	161.666667	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349
HHA CCN: 14-7694

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

Worksheet H-2 Part II
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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	15.00	16.00	17.00	19.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 10/22/2018 2:07 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	741,756		741,756	3,874	191.47	1.00
2.00	Physical Therapy	3.00	414,945	0	414,945	2,963	140.04	2.00
3.00	Occupational Therapy	4.00	182	0	182	236	0.77	3.00
4.00	Speech Pathology	5.00	18,618	0	18,618	83	224.31	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	512		512	4	128.00	6.00
7.00	Total (sum of lines 1-6)		1,176,013	0	1,176,013	7,160		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: 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		16060	0	100			8.00
8.01	Skilled Nursing Care		41180	0	161			8.01
8.02	Skilled Nursing Care		99914	0	1,797			8.02
9.00	Physical Therapy		16060	0	81			9.00
9.01	Physical Therapy		41180	0	124			9.01
9.02	Physical Therapy		99914	0	1,636			9.02
10.00	Occupational Therapy		16060	0	14			10.00
10.01	Occupational Therapy		41180	0	6			10.01
10.02	Occupational Therapy		99914	0	119			10.02
11.00	Speech Pathology		16060	0	9			11.00
11.01	Speech Pathology		41180	0	0			11.01
11.02	Speech Pathology		99914	0	40			11.02
12.00	Medical Social Services		16060	0	0			12.00
12.01	Medical Social Services		41180	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
13.00	Home Health Aide		16060	0	0			13.00
13.01	Home Health Aide		41180	0	0			13.01
13.02	Home Health Aide		99914	0	2			13.02
14.00	Total (sum of lines 8-13)			0	4,089			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	2,236	2,236	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: 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	2,058		0	394,045		1.00
2.00	Physical Therapy	0	1,841		0	257,814		2.00
3.00	Occupational Therapy	0	139		0	107		3.00
4.00	Speech Pathology	0	49		0	10,991		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	2		0	256		6.00
7.00	Total (sum of lines 1-6)	0	4,089		0	663,213		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1349 HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 10/22/2018 2:07 pm

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	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
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs	0	0	0		0	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	394,045	1.00
2.00	Physical Therapy	257,814	2.00
3.00	Occupational Therapy	107	3.00
4.00	Speech Pathology	10,991	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	256	6.00
7.00	Total (sum of lines 1-6)	663,213	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349 HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part II Date/Time Prepared: 10/22/2018 2:07 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.271205	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.165395	13,521	2,236	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.475828	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/22/2018 2:07 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	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	759,138	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	8,346	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,270	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,615	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	964	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	322	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	781,655	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	781,655	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	781,655	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	781,655	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	781,655	31.00
31.01	Sequestration adjustment (see instructions)	0	15,633	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	766,022	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: 14-1349 | HHA CCN: 14-7694 | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-5 | Date/Time Prepared: 10/22/2018 2:07 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		766,022	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		766,022	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		766,022	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 RHC/FQHC COSTS

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 10/22/2018 2:07 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,514,686	669,259	3,183,945	-192,240	2,991,705	1.00
2.00	Physician Assistant	347,601	0	347,601	0	347,601	2.00
3.00	Nurse Practitioner	448,191	42,880	491,071	0	491,071	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	986,451	0	986,451	0	986,451	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	14,202	14,202	0	14,202	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)	4,296,929	726,341	5,023,270	-192,240	4,831,030	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	414,476	414,476	0	414,476	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	146,688	146,688	0	146,688	18.00
19.00	Other Health Care Costs	0	33,474	33,474	0	33,474	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	594,638	594,638	0	594,638	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,296,929	1,320,979	5,617,908	-192,240	5,425,668	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	86,488	86,488	-17,188	69,300	29.00
30.00	Administrative Costs	681,828	166,572	848,400	22,206	870,606	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	681,828	253,060	934,888	5,018	939,906	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,978,757	1,574,039	6,552,796	-187,222	6,365,574	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 10/22/2018 2:07 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,991,705		1.00
2.00	Physician Assistant	-6,819	340,782		2.00
3.00	Nurse Practitioner	0	491,071		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	986,451		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	14,202		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)	-6,819	4,824,211		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	414,476		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	146,688		18.00
19.00	Other Health Care Costs	0	33,474		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	594,638		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-6,819	5,418,849		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	69,300		29.00
30.00	Administrative Costs	0	870,606		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	939,906		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,819	6,358,755		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1349 | Component CCN: 14-3464 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 10/22/2018 2:07 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	7.71	25,871	4,200	32,382		1.00
2.00	Physician Assistant	3.84	9,140	2,100	8,064		2.00
3.00	Nurse Practitioner	2.96	11,675	2,100	6,216		3.00
4.00	Subtotal (sum of lines 1 through 3)	14.51	46,686		46,662	46,686	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	0.16	88			88	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)	14.67	46,774			46,774	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)					5,418,849	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,418,849	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					939,906	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,457,464	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,397,370	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,397,370	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,397,370	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					10,816,219	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 10/22/2018 2:07 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			10,816,219	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			434,067	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			10,382,152	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			46,774	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)			46,774	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			221.96	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	221.96	221.96		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	13,157		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,920,328		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,920,328		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,665,892		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		75,885		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		133,027		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.)		2,100,620		16.04
16.05	Total program cost (see instructions)	0	2,233,647		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		161,526		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		285,696		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,233,647		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		137,221		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,370,868		22.00
23.00	Allowable bad debts (see instructions)		67,041		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		43,577		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		65,383		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)		2,414,445		26.00
26.01	Sequestration adjustment (see instructions)		48,289		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,897,406		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)		468,750		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: 14-1349 Component CCN: 14-3464	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 10/22/2018 2:07 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,824,211	4,824,211	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000965	0.002376	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,655	11,462	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	145,779	55,570	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	150,434	67,032	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,418,849	5,418,849	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,397,370	5,397,370	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027761	0.012370	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	149,836	66,765	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	300,270	133,797	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	881	2,169	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	340.83	61.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	256	810	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	87,252	49,969	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)		434,067	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)		137,221	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 10/22/2018 2:07 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,839,142	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		01/11/2018	58,264	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)		58,264	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,897,406	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		468,750	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,366,156	7.00

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