

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: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 12:28 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date:	Time:
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 BLESSING HOSPITAL ( 14-0015 ) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	665,359	10,321	0	0	1.00
2.00 Subprovider - IPF	0	135,591	-130		0	2.00
3.00 Subprovider - IRF	0	110,581	-120		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	60,763	-48,414		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		25,490		0	10.00
200.00 Total	0	972,294	-12,853	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: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 12:28 am									
1.00		2.00		3.00		4.00											
Hospital and Hospital Health Care Complex Address:																	
1.00	Street: 1005 BROADWAY			PO Box:				1.00									
2.00	City: QUINCY			State: IL		Zip Code: 62301		County:			2.00						
Component Name																	
1.00																	
2.00																	
3.00																	
4.00																	
5.00																	
6.00																	
7.00																	
8.00																	
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11.00																	
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13.00																	
14.00																	
15.00																	
16.00																	
17.00																	
18.00																	
19.00																	
Hospital and Hospital-Based Component Identification:																	
3.00	Hospital			BLESSING HOSPITAL		140015		99914		1	07/01/1966	N	P	O	3.00		
4.00	Subprovider - IPF			BLESSING PSYCHIATRIC UNIT		14S015		99914		4	10/01/1993	N	P	O	4.00		
5.00	Subprovider - IRF			BLESSING REHAB UNIT		14T015		99914		5	10/01/1985	N	P	O	5.00		
6.00	Subprovider - (Other)														6.00		
7.00	Swing Beds - SNF														7.00		
8.00	Swing Beds - NF														8.00		
9.00	Hospital-Based SNF			BLESSING SKILLED CARE UNIT		145643		99914			06/20/1989	N	P	N	9.00		
10.00	Hospital-Based NF														10.00		
11.00	Hospital-Based OLTC														11.00		
12.00	Hospital-Based HHA			BLESSING HOME CARE		147031		99914			12/01/1984	N	P	N	12.00		
13.00	Separately Certified ASC														13.00		
14.00	Hospital-Based Hospice			HOSPICE OF ADAMS COUNTY		141501		99914			06/01/1984		O	N	14.00		
15.00	Hospital-Based Health Clinic - RHC			GOLDEN CLINIC		143422		99914			09/08/1996	N	O	N	15.00		
16.00	Hospital-Based Health Clinic - FOHC														16.00		
17.00	Hospital-Based (CMHC) I														17.00		
18.00	Renal Dialysis														18.00		
19.00	Other														19.00		
											From:		To:				
											1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)										10/01/2017		09/30/2018		20.00		
21.00	Type of Control (see instructions)										2				21.00		
											1.00		2.00		3.00		
Inpatient PPS Information																	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.										Y	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										N	Y			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.										N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										N	N	N		22.03		
23.00	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.																
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.										5,675	0	1,192	0	3,079	0	24.00

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	158	0	48	0	79			25.00
							Urban/Rural	S	Date of Geogr
							1.00		2.00
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1			35.00
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					10/01/2017	09/30/2018		36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
							V	XVII	XIX
							1.00	2.00	3.00
<u>Prospective Payment System (PPS)-Capital</u>									
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
<u>Teaching Hospitals</u>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			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 Criteria Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					20.00	1		60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.01	1		60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.02	1		60.03

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1	60.04		
60.05	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.04	1	60.05		
60.06	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.05	1	60.06		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings					0.00	62.01
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

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
			Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010. 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

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
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.	Y				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		76.00
					1.00	
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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.			N		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
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.06
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a CAH?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					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.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 12:28 am		
		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.						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.				Y			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:	628,169		1,110,105		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.				Y			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.				Y	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)				Y	14H132		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 12:28 am																																									
1.00		2.00		3.00																																									
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.																																													
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131																																									
142.00	Street: BROADWAY AT 11TH STREET	PO Box:																																											
143.00	City: QUINCY	State: IL	Zip Code:	62301																																									
144.00 Are provider based physicians' costs included in Worksheet A?																																													
Y																																													
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.																																													
Y																																													
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																																													
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.																																													
N																																													
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.																																													
N																																													
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.																																													
N																																													
<table border="1"> <thead> <tr> <th>Part A</th> <th>Part B</th> <th>Title V</th> <th>Title XIX</th> </tr> <tr> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> </tr> </thead> <tbody> <tr> <td colspan="4">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)</td> </tr> <tr> <td>155.00 Hospital</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>156.00 Subprovider - IPF</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>157.00 Subprovider - IRF</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>158.00 SUBPROVIDER</td> <td></td> <td></td> <td></td> </tr> <tr> <td>159.00 SNF</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>160.00 HOME HEALTH AGENCY</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>161.00 CMHC</td> <td>N</td> <td>N</td> <td>N</td> </tr> </tbody> </table>						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	156.00 Subprovider - IPF	N	N	N	157.00 Subprovider - IRF	N	N	N	158.00 SUBPROVIDER				159.00 SNF	N	N	N	160.00 HOME HEALTH AGENCY	N	N	N	161.00 CMHC	N	N	N
Part A	Part B	Title V	Title XIX																																										
1.00	2.00	3.00	4.00																																										
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155.00 Hospital	N	N	N																																										
156.00 Subprovider - IPF	N	N	N																																										
157.00 Subprovider - IRF	N	N	N																																										
158.00 SUBPROVIDER																																													
159.00 SNF	N	N	N																																										
160.00 HOME HEALTH AGENCY	N	N	N																																										
161.00 CMHC	N	N	N																																										
165.00 Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.																																													
N																																													
<table border="1"> <thead> <tr> <th>Name</th> <th>County</th> <th>State</th> <th>Zip Code</th> <th>CBSA</th> <th>FTE/Campus</th> </tr> <tr> <th>0</th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">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)</td> </tr> <tr> <td colspan="6">0.00</td> </tr> </tbody> </table>						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																					
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																																													
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.																																													
Y																																													
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																																													
168.01 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																																													
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)																																													
<table border="1"> <thead> <tr> <th>Beginning</th> <th>Ending</th> </tr> <tr> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td>12/08/2010</td> <td>03/07/2011</td> </tr> </tbody> </table>						Beginning	Ending	1.00	2.00	12/08/2010	03/07/2011																																		
Beginning	Ending																																												
1.00	2.00																																												
12/08/2010	03/07/2011																																												
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)																																													
N																																													
0																																													

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 12:28 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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?	Y	Y				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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.	Y					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.			Y			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2018	Y	12/31/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 12:28 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE		ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159		CZIEGLER@BLESSINGHOSPITAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 12:28 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT COORDINATOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part IX Date/Time Prepared: 2/27/2019 12:28 am	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		N	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
			Inpatient	Outpatient	
			1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
<b>RCE DISALLOWANCE</b>					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		N	Y	6.00
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		N	Y	7.00
<b>RHC</b>					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
<b>FQHC</b>					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	223	80,775	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		223	80,775	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	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	43.00				0	13.00
14.00 Total (see instructions)		248	89,900	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	41	14,965		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		327				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: 14-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	25,239	4,122	43,174			1.00
2.00 HMO and other (see instructions)	3,733	4,417				2.00
3.00 HMO IPF Subprovider	61	1,589				3.00
4.00 HMO IRF Subprovider	374	79				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	25,239	4,122	43,174			7.00
8.00 INTENSIVE CARE UNIT	2,757	492	5,344			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		822	2,413			13.00
14.00 Total (see instructions)	27,996	5,436	50,931	16.99	2,011.38	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,630	4,460	12,380	0.39	78.99	16.00
17.00 SUBPROVIDER - IRF	3,329	206	4,885	0.54	25.21	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,585	18	6,109	0.00	30.60	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	29,830	0	45,775	0.00	48.09	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	17.94	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,122	0	7,197	0.00	7.81	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)				17.92	2,220.02	27.00
28.00 Observation Bed Days		0	6,499			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			766			30.00
31.00 Employee discount days - IRF			26			31.00
32.00 Labor & delivery days (see instructions)	0	93	425			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: 14-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	6,212	1,322	12,588	1.00
2.00 HMO and other (see instructions)			775	862		2.00
3.00 HMO IPF Subprovider				450		3.00
4.00 HMO IRF Subprovider				7		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	6,212	1,322	12,588	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	227	699	1,975	16.00
17.00 SUBPROVIDER - IRF	0.00	0	236	19	356	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part II Date/Time Prepared: 2/27/2019 12:28 am			
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	130,628,946	0	130,628,946	4,605,889.97	28.36	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		166,381	0	166,381	1,073.00	155.06	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		11,585,227	0	11,585,227	85,431.01	135.61	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		359,742	0	359,742	14,079.08	25.55	6.00
7.00	Interns & residents (in an approved program)	21.00	1,110,470	0	1,110,470	39,628.68	28.02	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,575,718	-28,387	1,547,331	62,684.90	24.68	9.00
10.00	Excluded area salaries (see instructions)		15,425,638	875,378	16,301,016	528,039.03	30.87	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		5,310,336	0	5,310,336	72,583.64	73.16	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		346,233	0	346,233	2,235.62	154.87	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,996,740	0	5,996,740	70,166.45	85.46	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		35,282,843	0	35,282,843			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,794,058	0	5,794,058			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		31,399	0	31,399			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		2,238,130	0	2,238,130			23.00
24.00	Wage-related costs (RHC/FQHC)		127,898	0	127,898			24.00
25.00	Interns & residents (in an approved program)		375,161	0	375,161			25.00
25.50	Home office wage-related (core)		1,298,355	0	1,298,355			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	2,772,874	0	2,772,874	172,658.55	16.06	26.00
27.00	Administrative & General	5.00	22,524,002	-10,090	22,513,912	823,804.29	27.33	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	890,930	0	890,930	4,095.00	217.57	28.00
29.00	Maintenance & Repairs	2,697,390	0	2,697,390	120,498.54	22.39	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	37,365	0	37,365	2,610.88	14.31	31.00
32.00	Housekeeping	2,462,405	0	2,462,405	175,220.88	14.05	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	2,497,578	-1,553,494	944,084	67,529.28	13.98	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,553,494	1,553,494	111,119.61	13.98	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	7,579,797	-63,470	7,516,327	245,931.79	30.56	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	3,638,709	0	3,638,709	179,800.16	20.24	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2019 12:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	118,464,437	0	118,464,437	4,470,846.20	26.50	1.00
2.00	Excluded area salaries (see instructions)	17,001,356	846,991	17,848,347	590,723.93	30.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)	101,463,081	-846,991	100,616,090	3,880,122.27	25.93	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,653,309	0	11,653,309	144,985.71	80.38	4.00
5.00	Subtotal wage-related costs (see inst.)	36,612,597	0	36,612,597	0.00	36.39	5.00
6.00	Total (sum of lines 3 thru 5)	149,728,987	-846,991	148,881,996	4,025,107.98	36.99	6.00
7.00	Total overhead cost (see instructions)	45,101,050	-73,560	45,027,490	1,903,268.98	23.66	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 12:28 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	5,103,731	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	5,979,667	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	21,499,290	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	141,311	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	347,486	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	982,035	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	8,640,776	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	99,653	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,055,541	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	43,849,490	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part V Date/Time Prepared: 2/27/2019 12:28 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		5,630,410	43,849,490 1.00
2.00	Hospital		5,310,336	35,282,843 2.00
3.00	Subprovider - IPF		84,646	1,344,710 3.00
4.00	Subprovider - IRF		150,621	470,452 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		84,807	502,306 8.00
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	1,024,772 11.00
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice		0	359,348 13.00
14.00	Hospital-Based Health Clinic RHC		0	127,898 14.00
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	4,737,161 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0015 Component CCN: 14-7031		Period: From 10/01/2017 To 09/30/2018		Worksheet S-4 Date/Time Prepared: 2/27/2019 12:28 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			ADAMS		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	11,590	0	4,233	15,823	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	997.00	0.00	802.00	1,799.00	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		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			8.65	0.00	8.65	5.00
6.00	Direct Nursing Service			15.22	0.00	15.22	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			11.55	0.00	11.55	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.61	0.00	2.61	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.45	0.00	0.45	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.00	0.00	1.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			7.61	0.00	7.61	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).			99914			20.00
20.01				99926			20.01
20.02				17860			20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	12,116	2,126	280	123	14,645	21.00
22.00	Skilled Nursing Visit Charges	1,962,792	344,412	45,360	19,926	2,372,490	22.00
23.00	Physical Therapy Visits	8,295	113	82	103	8,593	23.00
24.00	Physical Therapy Visit Charges	1,343,790	18,306	13,284	16,686	1,392,066	24.00
25.00	Occupational Therapy Visits	2,190	97	18	29	2,334	25.00
26.00	Occupational Therapy Visit Charges	354,780	15,714	2,916	4,698	378,108	26.00
27.00	Speech Pathology Visits	209	9	2	0	220	27.00
28.00	Speech Pathology Visit Charges	33,858	1,458	324	0	35,640	28.00
29.00	Medical Social Service Visits	33	4	0	1	38	29.00
30.00	Medical Social Service Visit Charges	5,346	648	0	162	6,156	30.00
31.00	Home Health Aide Visits	3,170	799	6	25	4,000	31.00
32.00	Home Health Aide Visit Charges	285,300	71,910	540	2,250	360,000	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	26,013	3,148	388	281	29,830	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)	3,985,866	452,448	62,424	43,722	4,544,460	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,410		141	24	1,575	36.00
37.00	Total Number of Outlier Episodes		55		1	56	37.00
38.00	Total Non-Routine Medical Supply Charges	145,129	42,484	2,296	279	190,188	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0015

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

Worksheet S-7

Date/Time Prepared:  
2/27/2019 12:28 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	14	0	14 6.00
7.00		RHX	39	0	39 7.00
8.00		RHL	25	0	25 8.00
9.00		RMX	14	0	14 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	12	0	12 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	34	0	34 15.00
16.00		RVB	32	0	32 16.00
17.00		RVA	27	0	27 17.00
18.00		RHC	848	0	848 18.00
19.00		RHB	1,236	0	1,236 19.00
20.00		RHA	910	0	910 20.00
21.00		RMC	288	0	288 21.00
22.00		RMB	279	0	279 22.00
23.00		RMA	109	0	109 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	6	0	6 27.00
28.00		ES1	2	0	2 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	13	0	13 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	54	0	54 32.00
33.00		HC2	28	0	28 33.00
34.00		HC1	106	0	106 34.00
35.00		HB2	39	0	39 35.00
36.00		HB1	100	0	100 36.00
37.00		LE2	4	0	4 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	20	0	20 39.00
40.00		LD1	15	0	15 40.00
41.00		LC2	5	0	5 41.00
42.00		LC1	26	0	26 42.00
43.00		LB2	10	0	10 43.00
44.00		LB1	97	0	97 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	7	0	7 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	26	0	26 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	36	0	36 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	63	0	63 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	57	0	57 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0015

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

Worksheet S-7

Date/Time Prepared:  
2/27/2019 12:28 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,585	0	4,585	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	1,575,718	25.45	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	6,191,559			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0015 Component CCN: 14-3422		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/27/2019 12:28 am	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	102 PRAIRIE MILLS ROAD				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	GOLDEN		IL		62339	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			Grant Award		Date	
				1.00		2.00	
4.00	Source of Federal Funds 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	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) CLINIC	08:00		17:00		08:00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N				0	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number	Y/N		V		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)						
				County			
				4.00			
2.00	City, State, ZIP Code, County	ADAMS				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) CLINIC	17:00		08:00		17:00	
				17:00		08:00	
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0015 Component CCN: 14-3422		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/27/2019 12:28 am	
				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00				11.00

HOSPITAL-BASED HOSPI CE IDENTIFICATION DATA		Provider CCN: 14-0015 Hospice CCN: 14-1501	Period: From 10/01/2017 To 09/30/2018	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/27/2019 12:28 am
		Hospice I		

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
<b>PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	9,695	475	450	10,620	11.00
12.00	Hospice Inpatient Respite Care	0	4	0	4	12.00
13.00	Hospice General Inpatient Care	300	26	37	363	13.00
14.00	Total Hospice Days	9,995	505	487	10,987	14.00
<b>PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
15.00	Hospice Inpatient Respite Care	0	4	0	4	15.00
16.00	Hospice General Inpatient Care	300	26	37	363	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/27/2019 12:28 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.196759	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		25,753,376	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		12,637,237	5.00	
6.00	Medicaid charges		216,687,125	6.00	
7.00	Medicaid cost (line 1 times line 6)		42,635,142	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)		4,244,529	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,244,529	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	23,506,234	1,513,979	25,020,213	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,625,063	1,513,979	6,139,042	21.00
22.00	Payments received from patients for amounts previously written off as charity care	143,017	219,843	362,860	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,482,046	1,294,136	5,776,182	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)		18,069,907	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,428,123	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,197,112	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		15,872,795	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,892,104	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		9,668,286	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,912,815	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING	655	655	26,045	26,700	1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	4,788,105	4,788,105	-496	4,787,609	1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1,645,325	1,645,325	1,909,912	3,555,237	1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	92,171	92,171	1.04	
1.05	00105	CAP REL COSTS-BBC	0	0	242,011	242,011	1.05	
1.06	00106	CAP REL COSTS-BEC	0	0	119,297	119,297	1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,801,366	10,801,366	139,990	10,941,356	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,772,874	39,521,684	42,294,558	42,294,558	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	22,524,002	109,379,331	131,903,333	-517,985	131,385,348	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,697,390	5,774,265	8,471,655	0	8,471,655	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,365	1,230,462	1,267,827	0	1,267,827	8.00
9.00	00900	HOUSEKEEPING	2,462,405	1,215,973	3,678,378	0	3,678,378	9.00
10.00	01000	DIETARY	2,497,578	4,020,091	6,517,669	-4,053,991	2,463,678	10.00
11.00	01100	CAFETERIA	0	0	0	4,053,991	4,053,991	11.00
13.00	01300	NURSING ADMINISTRATION	7,579,797	385,942	7,965,739	-63,536	7,902,203	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,638,709	926,116	4,564,825	0	4,564,825	16.00
20.00	02000	NURSING SCHOOL	3,572,011	2,372,140	5,944,151	651,713	6,595,864	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,110,470	0	1,110,470	0	1,110,470	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,951,903	1,951,903	0	1,951,903	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	285,082	16,737	301,819	0	301,819	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	69,606	3,020	72,626	0	72,626	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	292,286	19,972	312,258	0	312,258	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	191,654	191,654	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	49,936	49,936	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	17,989,587	6,643,420	24,633,007	-508,073	24,124,934	30.00
31.00	03100	INTENSIVE CARE UNIT	3,859,572	2,173,339	6,032,911	-236,372	5,796,539	31.00
40.00	04000	SUBPROVIDER - I PF	4,163,767	214,963	4,378,730	-23,382	4,355,348	40.00
41.00	04100	SUBPROVIDER - I RF	1,477,980	281,011	1,758,991	-34,179	1,724,812	41.00
43.00	04300	NURSERY	367,944	58,340	426,284	-47,107	379,177	43.00
44.00	04400	SKILLED NURSING FACILITY	1,575,718	200,677	1,776,395	-43,360	1,733,035	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	10,155,218	20,612,628	30,767,846	-14,815,489	15,952,357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,284,656	322,730	1,607,386	-158,513	1,448,873	52.00
53.00	05300	ANESTHESIOLOGY	210,369	649,383	859,752	-284,771	574,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,730,444	2,259,937	6,990,381	-289,545	6,700,836	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,182,878	383,285	1,566,163	-5,662	1,560,501	55.00
57.00	05700	CT SCAN	542,369	330,204	872,573	-34,000	838,573	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	326,231	311,396	637,627	421	638,048	58.00
60.00	06000	LABORATORY	3,053,446	3,813,788	6,867,234	-38,096	6,829,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	127,961	1,381,287	1,509,248	0	1,509,248	62.00
65.00	06500	RESPIRATORY THERAPY	2,133,860	516,475	2,650,335	-232,554	2,417,781	65.00
66.00	06600	PHYSICAL THERAPY	1,384,387	21,334	1,405,721	-1,272	1,404,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	743,865	9,213	753,078	-1,234	751,844	67.00
68.00	06800	SPEECH PATHOLOGY	222,402	10,237	232,639	-1,667	230,972	68.00
69.00	06900	ELECTROCARDIOLOGY	2,028,023	9,125,974	11,153,997	-8,336,510	2,817,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	425,750	99,286	525,036	25,776	550,812	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	867,598	1,136,692	2,004,290	9,736,983	11,741,273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,762,495	14,762,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,195,420	16,778,823	20,974,243	-5,076	20,969,167	73.00
74.00	07400	RENAL DIALYSIS	0	865,802	865,802	-277	865,525	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	609,997	376,227	986,224	-988	985,236	88.00
90.00	09000	CLINIC	428,327	84,735	513,062	-128	512,934	90.00
90.01	04950	OUTPATIENT INFUSION	330,696	65,776	396,472	-11,071	385,401	90.01
91.00	09100	EMERGENCY	11,106,000	2,206,853	13,312,853	-116,944	13,195,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	3,156,765	1,147,815	4,304,580	-7,169	4,297,411	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	2,166,968	2,166,968	-2,166,968	0	113.00
116.00	11600	HOSPICE	1,096,866	358,553	1,455,419	11,751	1,467,170	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,317,671	258,660,238	387,977,909	-22,269	387,955,640	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	915,045	344,688	1,259,733	0	1,259,733	192.00
192.01	19201	FASTCARE	186,353	49,102	235,455	0	235,455	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

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

Worksheet A

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	22,269	22,269	193.05
193.06	19306	AUGUSTA PHARMACY	209,877	676,298	886,175	0	886,175	193.06
200.00		TOTAL (SUM OF LINES 118 through 199)	130,628,946	259,730,326	390,359,272	0	390,359,272	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	9,363	36,063	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-4,351,476	436,133	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	2,772,661	6,327,898	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	-43,754	48,417	1.04
1.05	00105	CAP REL COSTS-BBC	218,670	460,681	1.05
1.06	00106	CAP REL COSTS-BEC	373,766	493,063	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,676,688	13,618,044	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-28,617,125	13,677,433	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-77,100,101	54,285,247	5.00
6.00	00600	MAINTENANCE & REPAIRS	-625,869	7,845,786	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,783	1,270,610	8.00
9.00	00900	HOUSEKEEPING	-369,940	3,308,438	9.00
10.00	01000	DIETARY	-1,043,466	1,420,212	10.00
11.00	01100	CAFETERIA	-1,497,846	2,556,145	11.00
13.00	01300	NURSING ADMINISTRATION	-253,721	7,648,482	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,181,143	5,745,968	16.00
20.00	02000	NURSING SCHOOL	-4,800,617	1,795,247	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,110,470	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,951,903	22.00
23.00	02300	PARAMED PRGM	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	-74,875	226,944	23.01
23.02	02302	PARAMED PRGM-LABORATORY	-27,947	44,679	23.02
23.03	02303	PARAMED PRGM-PHARMACY	-5,000	307,258	23.03
23.04	02304	PARAMED PRGM-RESPIRATORY	0	191,654	23.04
23.05	02305	PARAMED PRGM-HIM	0	49,936	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-3,372,331	20,752,603	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,341,366	4,455,173	31.00
40.00	04000	SUBPROVIDER - IPF	-4,102	4,351,246	40.00
41.00	04100	SUBPROVIDER - IRF	-9,477	1,715,335	41.00
43.00	04300	NURSERY	0	379,177	43.00
44.00	04400	SKILLED NURSING FACILITY	-483	1,732,552	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,567,689	14,384,668	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,448,873	52.00
53.00	05300	ANESTHESIOLOGY	-1,113	573,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,252,316	5,448,520	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,560,501	55.00
57.00	05700	CT SCAN	0	838,573	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	638,048	58.00
60.00	06000	LABORATORY	-1,938	6,827,200	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,509,248	62.00
65.00	06500	RESPIRATORY THERAPY	-16,806	2,400,975	65.00
66.00	06600	PHYSICAL THERAPY	0	1,404,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	751,844	67.00
68.00	06800	SPEECH PATHOLOGY	0	230,972	68.00
69.00	06900	ELECTROCARDIOLOGY	-9,530	2,807,957	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-31,281	519,531	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-73,668	11,667,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,762,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,639,682	18,329,485	73.00
74.00	07400	RENAL DIALYSIS	0	865,525	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-47,906	937,330	88.00
90.00	09000	CLINIC	0	512,934	90.00
90.01	04950	OUTPATIENT INFUSION	0	385,401	90.01
91.00	09100	EMERGENCY	-7,340,787	5,855,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	-9,911	4,287,500	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	88,043	1,555,213	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-129,209,006	258,746,634	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,259,733	192.00
192.01	19201	FASTCARE	-50	235,405	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	193.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.03	19303	UNUSED SPACE	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	193.04
193.05	19305	RENTED SPACE	0	22,269	193.05
193.06	19306	AUGUSTA PHARMACY	0	886,175	193.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-129,209,056	261,150,216	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0015

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

Worksheet Non-CMS W  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01 CAP REL COSTS-BUTLER BUILDING	00101		1.01
1.02 CAP REL COSTS-OLD BLDG & FIXTURES	00102		1.02
1.03 CAP REL COSTS-NEW BLDG & FIXTURES	00103		1.03
1.04 CAP REL COSTS-MOB PHASE I	00104		1.04
1.05 CAP REL COSTS-BBC	00105		1.05
1.06 CAP REL COSTS-BEC	00106		1.06
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00 OTHER CAP REL COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
20.00 NURSING SCHOOL	02000		20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
23.00 PARAMED PRGM	02300		23.00
23.01 PARAMED PRGM-RADIOLOGY	02301		23.01
23.02 PARAMED PRGM-LABORATORY	02302		23.02
23.03 PARAMED PRGM-PHARMACY	02303		23.03
23.04 PARAMED PRGM-RESPIRATORY	02304		23.04
23.05 PARAMED PRGM-HIM	02305		23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
41.00 SUBPROVIDER - IRF	04100		41.00
43.00 NURSERY	04300		43.00
44.00 SKILLED NURSING FACILITY	04400		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY-THERAPEUTIC	05500		55.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00 LABORATORY	06000		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC	08800		88.00
90.00 CLINIC	09000		90.00
90.01 OUTPATIENT INFUSION	04950		90.01
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00 HOME HEALTH AGENCY	10100		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE	11300		113.00
116.00 HOSPICE	11600		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 FASTCARE	19201		192.01
193.00 NONPAID WORKERS	19300		193.00

COST CENTERS USED IN COST REPORT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet Non-CMS W Date/Time Prepared: 2/27/2019 12:28 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
193.01	DENMAN SERVICES	19301		193.01
193.02	MEALS ON WHEELS	19302		193.02
193.03	UNUSED SPACE	19303		193.03
193.04	HEALTH EDUCATION	19304		193.04
193.05	RENTED SPACE	19305		193.05
193.06	AUGUSTA PHARMACY	19306		193.06
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6

Date/Time Prepared:  
2/27/2019 12:28 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS CAFETERIA COSTS</b>					
1.00	CAFETERIA	11.00	1,553,494	2,500,497	1.00
	TOTALS		1,553,494	2,500,497	
<b>B - RECLASS C-SECTION COSTS</b>					
1.00	OPERATING ROOM	50.00	13,363	0	1.00
	TOTALS		13,363	0	
<b>C - RECLASS BBC RENT EXPENSE</b>					
1.00	CAP REL COSTS-BBC	1.05	0	242,011	1.00
2.00	CAP REL COSTS-BEC	1.06	0	119,297	2.00
	TOTALS		0	361,308	
<b>D - RECLASS CAPITAL RELATED INSURANCE</b>					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	26,045	1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	50,024	2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	72,257	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,617	4.00
	TOTALS		0	159,943	
<b>E - RECLASS VOLUNTEER SERVICES</b>					
1.00	HOSPICE	116.00	10,090	2,444	1.00
	TOTALS		10,090	2,444	
<b>F - RECLASS HEALTH EDUCATION</b>					
1.00	RENTED SPACE	193.05	22,203	66	1.00
	TOTALS		22,203	66	
<b>G - RECLASS INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1,837,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	128,373	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	200,940	3.00
	TOTALS		0	2,166,968	
<b>H - RECLASS ER PHYSICIAN MALPRACTIC INS</b>					
1.00	EMERGENCY	91.00	0	92,969	1.00
	TOTALS		0	92,969	
<b>I - RECLASS CHARGEABLE MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,736,983	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,762,495	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	421	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	24,499,899	
<b>J - RECLASS PRECEPTOR PAY</b>					
1.00	NURSING SCHOOL	20.00	893,303	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6

Date/Time Prepared:  
2/27/2019 12:28 am

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		893,303	0		
K - RECLASS RENT EXPENSE						
1.00	CAP REL COSTS-MOB PHASE I	1.04	0	92,171		1.00
	TOTALS		0	92,171		
L - RECLASS LEASEHOLD IMPROVEMENT DEPR						
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	26,116		1.00
2.00	RESPIRATORY THERAPY	65.00	0	12,491		2.00
3.00	LABORATORY	60.00	0	11,913		3.00
	TOTALS		0	50,520		
M - RECLASS OTHER PARAMEDIC PROGRAMS						
1.00	PARAMED ED PRGM-RESPIRATORY	23.04	147,949	43,705		1.00
2.00	PARAMED ED PRGM-HIM	23.05	33,051	16,885		2.00
	TOTALS		181,000	60,590		
500.00	Grand Total: Increases		2,673,453	29,987,375		500.00

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6  
Date/Time Prepared:  
2/27/2019 12:28 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS CAFETERIA COSTS</b>							
1.00	DIETARY	10.00	1,553,494	2,500,497	0		1.00
	TOTALS		1,553,494	2,500,497			
<b>B - RECLASS C-SECTION COSTS</b>							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	13,363	0	0		1.00
	TOTALS		13,363	0			
<b>C - RECLASS BBC RENT EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	361,308	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	361,308			
<b>D - RECLASS CAPITAL RELATED INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	159,943	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	159,943			
<b>E - RECLASS VOLUNTEER SERVICES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	10,090	2,444	0		1.00
	TOTALS		10,090	2,444			
<b>F - RECLASS HEALTH EDUCATION</b>							
1.00	NURSING ADMINISTRATION	13.00	22,203	66	0		1.00
	TOTALS		22,203	66			
<b>G - RECLASS INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	2,166,968	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	2,166,968			
<b>H - RECLASS ER PHYSICIAN MALPRACTIC INS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,969	0		1.00
	TOTALS		0	92,969			
<b>I - RECLASS CHARGEABLE MEDICAL SUPPLIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	79,850	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	108,578	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,937	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	5,406	0		4.00
5.00	NURSERY	43.00	0	26,462	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	14,973	0		6.00
7.00	OPERATING ROOM	50.00	0	14,735,307	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	135,622	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	284,771	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	289,545	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,662	0		11.00
12.00	CT SCAN	57.00	0	34,000	0		12.00
13.00	LABORATORY	60.00	0	50,009	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	236,253	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	1,272	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	1,234	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	1,667	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	8,336,510	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	340	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,076	0		20.00
21.00	RENAL DIALYSIS	74.00	0	277	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	988	0		22.00
23.00	CLINIC	90.00	0	128	0		23.00
24.00	OUTPATIENT INFUSION	90.01	0	11,071	0		24.00
25.00	EMERGENCY	91.00	0	125,009	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	7,169	0		26.00
27.00	HOSPICE	116.00	0	783	0		27.00
	TOTALS		0	24,499,899			
<b>J - RECLASS PRECEPTOR PAY</b>							
1.00	NURSING ADMINISTRATION	13.00	41,267	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	428,223	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	127,794	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	21,445	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	28,773	0	0		5.00
6.00	NURSERY	43.00	20,645	0	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	28,387	0	0		7.00
8.00	OPERATING ROOM	50.00	93,545	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	9,528	0	0		9.00
10.00	RESPIRATORY THERAPY	65.00	8,792	0	0		10.00
11.00	EMERGENCY	91.00	84,904	0	0		11.00
	TOTALS		893,303	0	0		

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6

Date/Time Prepared:  
2/27/2019 12:28 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
K - RECLASS RENT EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,171	10		1.00
	TOTALS		0	92,171			
L - RECLASS LEASEHOLD IMPROVEMENT DEPR							
1.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	50,520	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	50,520			
M - RECLASS OTHER PARAMEDIC PROGRAMS							
1.00	NURSING SCHOOL	20.00	181,000	60,590	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		181,000	60,590			
500.00	Grand Total: Decreases		2,673,453	29,987,375			500.00

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
2/27/2019 12:28 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>A - RECLASS CAFETERIA COSTS</b>									
1.00	CAFETERIA	11.00	1,553,494	2,500,497	DIETARY	10.00	1,553,494	2,500,497	1.00
	TOTALS		1,553,494	2,500,497	TOTALS		1,553,494	2,500,497	
<b>B - RECLASS C-SECTION COSTS</b>									
1.00	OPERATING ROOM	50.00	13,363	0	DELIVERY ROOM & LABOR ROOM	52.00	13,363	0	1.00
	TOTALS		13,363	0	TOTALS		13,363	0	
<b>C - RECLASS BBC RENT EXPENSE</b>									
1.00	CAP REL COSTS-BBC	1.05	0	242,011	ADMINISTRATIVE & GENERAL	5.00	0	361,308	1.00
2.00	CAP REL COSTS-BEC	1.06	0	119,297		0.00	0	0	2.00
	TOTALS		0	361,308	TOTALS		0	361,308	
<b>D - RECLASS CAPITAL RELATED INSURANCE</b>									
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	26,045	ADMINISTRATIVE & GENERAL	5.00	0	159,943	1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	50,024		0.00	0	0	2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	72,257		0.00	0	0	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,617		0.00	0	0	4.00
	TOTALS		0	159,943	TOTALS		0	159,943	
<b>E - RECLASS VOLUNTEER SERVICES</b>									
1.00	HOSPICE	116.00	10,090	2,444	ADMINISTRATIVE & GENERAL	5.00	10,090	2,444	1.00
	TOTALS		10,090	2,444	TOTALS		10,090	2,444	
<b>F - RECLASS HEALTH EDUCATION</b>									
1.00	RENTED SPACE	193.05	22,203	66	NURSING ADMINISTRATION	13.00	22,203	66	1.00
	TOTALS		22,203	66	TOTALS		22,203	66	
<b>G - RECLASS INTEREST EXPENSE</b>									
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1,837,655	INTEREST EXPENSE	113.00	0	2,166,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	128,373		0.00	0	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	200,940		0.00	0	0	3.00
	TOTALS		0	2,166,968	TOTALS		0	2,166,968	
<b>H - RECLASS ER PHYSICIAN MALPRACTIC INS</b>									
1.00	EMERGENCY	91.00	0	92,969	ADMINISTRATIVE & GENERAL	5.00	0	92,969	1.00
	TOTALS		0	92,969	TOTALS		0	92,969	
<b>I - RECLASS CHARGEABLE MEDICAL SUPPLIES</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,736,983	ADULTS & PEDIATRICS	30.00	0	79,850	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,762,495	INTENSIVE CARE UNIT	31.00	0	108,578	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	421	SUBPROVIDER - I PF	40.00	0	1,937	3.00
4.00		0.00	0	0	SUBPROVIDER - I RF	41.00	0	5,406	4.00
5.00		0.00	0	0	NURSERY	43.00	0	26,462	5.00
6.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	14,973	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	14,735,307	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	135,622	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	284,771	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	289,545	10.00
11.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	5,662	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	34,000	12.00
13.00		0.00	0	0	LABORATORY	60.00	0	50,009	13.00
14.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	236,253	14.00
15.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	1,272	15.00
16.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	1,234	16.00
17.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	1,667	17.00
18.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	8,336,510	18.00
19.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	340	19.00
20.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	5,076	20.00
21.00		0.00	0	0	RENAL DIALYSIS	74.00	0	277	21.00
22.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	988	22.00
23.00		0.00	0	0	CLINIC	90.00	0	128	23.00
24.00		0.00	0	0	OUTPATIENT INFUSION	90.01	0	11,071	24.00
25.00		0.00	0	0	EMERGENCY	91.00	0	125,009	25.00

RECLASSIFICATIONS

Provider CCN: 14-0015

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
2/27/2019 12:28 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
26.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	7,169	26.00
27.00		0.00	0	0	HOSPICE	116.00	0	783	27.00
	TOTALS		0	24,499,899	TOTALS		0	24,499,899	
J - RECLASS PRECEPTOR PAY									
1.00	NURSING SCHOOL	20.00	893,303	0	NURSING	13.00	41,267	0	1.00
					ADMINISTRATION				
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	428,223	0	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	127,794	0	3.00
4.00		0.00	0	0	SUBPROVIDER - IPF	40.00	21,445	0	4.00
5.00		0.00	0	0	SUBPROVIDER - IRF	41.00	28,773	0	5.00
6.00		0.00	0	0	NURSERY	43.00	20,645	0	6.00
7.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	28,387	0	7.00
8.00		0.00	0	0	OPERATING ROOM	50.00	93,545	0	8.00
9.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	9,528	0	9.00
10.00		0.00	0	0	RESPIRATORY THERAPY	65.00	8,792	0	10.00
11.00		0.00	0	0	EMERGENCY	91.00	84,904	0	11.00
	TOTALS		893,303	0	TOTALS		893,303	0	
K - RECLASS RENT EXPENSE									
1.00	CAP REL COSTS-MOB PHASE I	1.04	0	92,171	ADMINISTRATIVE & GENERAL	5.00	0	92,171	1.00
	TOTALS		0	92,171	TOTALS		0	92,171	
L - RECLASS LEASEHOLD IMPROVEMENT DEPR									
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	26,116	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	50,520	1.00
2.00	RESPIRATORY THERAPY	65.00	0	12,491		0.00	0	0	2.00
3.00	LABORATORY	60.00	0	11,913		0.00	0	0	3.00
	TOTALS		0	50,520	TOTALS		0	50,520	
M - RECLASS OTHER PARAMEDIC PROGRAMS									
1.00	PARAMED PRGM-RESPIRATORY	23.04	147,949	43,705	NURSING SCHOOL	20.00	181,000	60,590	1.00
2.00	PARAMED PRGM-HIM	23.05	33,051	16,885		0.00	0	0	2.00
	TOTALS		181,000	60,590	TOTALS		181,000	60,590	
500.00	Grand Total: Increases		2,673,453	29,987,375	Grand Total: Decreases		2,673,453	29,987,375	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	14,395,667	57,270	0	57,270	0 1.00
2.00	Land Improvements	7,183,113	852,344	0	852,344	2,590 2.00
3.00	Buildings and Fixtures	139,381,011	1,292,507	0	1,292,507	707,681 3.00
4.00	Building Improvements	3,564,673	0	0	0	0 4.00
5.00	Fixed Equipment	65,450,531	11,065,887	0	11,065,887	123,620 5.00
6.00	Movable Equipment	156,130,433	17,675,835	0	17,675,835	4,630,378 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	386,105,428	30,943,843	0	30,943,843	5,464,269 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	386,105,428	30,943,843	0	30,943,843	5,464,269 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	14,452,937	0			1.00
2.00	Land Improvements	8,032,867	0			2.00
3.00	Buildings and Fixtures	139,965,837	0			3.00
4.00	Building Improvements	3,564,673	0			4.00
5.00	Fixed Equipment	76,392,798	0			5.00
6.00	Movable Equipment	169,175,890	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	411,585,002	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	411,585,002	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	655	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	4,788,105	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,645,325	0	0	0	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.04
1.05	CAP REL COSTS-BBC	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BEC	0	0	0	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	10,801,366	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	17,235,451	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	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	655				1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	4,788,105				1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,645,325				1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0				1.04
1.05	CAP REL COSTS-BBC	0	0				1.05
1.06	CAP REL COSTS-BEC	0	0				1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,801,366				2.00
3.00	Total (sum of lines 1-2)	0	17,235,451				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	305,716	0	305,716	0.000786	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	172,815,551	0	172,815,551	0.444143	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	46,802,142	0	46,802,142	0.120283	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-BBC	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BEC	0	0	0	0.000000	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	169,175,890	0	169,175,890	0.434788	0	2.00
3.00	Total (sum of lines 1-2)	389,099,299	0	389,099,299	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	10,018	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	386,109	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	6,404,339	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	48,417	1.04
1.05	CAP REL COSTS-BBC	0	0	0	378,397	82,284	1.05
1.06	CAP REL COSTS-BEC	0	0	0	373,766	119,297	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,606,427	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,159,056	249,998	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 col. 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	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	26,045	0	0	36,063	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	50,024	0	0	436,133	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	-148,698	72,257	0	0	6,327,898	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	48,417	1.04
1.05	CAP REL COSTS-BBC	0	0	0	0	460,681	1.05
1.06	CAP REL COSTS-BEC	0	0	0	0	493,063	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,617	0	0	13,618,044	2.00
3.00	Total (sum of lines 1-2)	-148,698	159,943	0	0	21,420,299	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

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

Worksheet A-8

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst.	A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			OCAP REL COSTS-BUTLER BUILDING	1.01		0 1.01
1.02 Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)			OCAP REL COSTS-OLD BLDG & FIXTURES	1.02		0 1.02
1.03 Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)			OCAP REL COSTS-NEW BLDG & FIXTURES	1.03		0 1.03
1.04 Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			OCAP REL COSTS-MOB PHASE I	1.04		0 1.04
1.05 Investment income - CAP REL COSTS-BBC (chapter 2)			OCAP REL COSTS-BBC	1.05		0 1.05
1.06 Investment income - CAP REL COSTS-BEC (chapter 2)			OCAP REL COSTS-BEC	1.06		0 1.06
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00 Investment income - other (chapter 2)		0		0.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-237,751	ADMINISTRATIVE & GENERAL	5.00		0 7.00
8.00 Television and radio service (chapter 21)	A	-42,178	CAP REL COSTS-MVBLE EQUIP	2.00		9 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-28,194,993				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	16,469,098				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests	B	-1,497,846	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients	A	-2,384,061	DRUGS CHARGED TO PATIENTS	73.00		0 17.00
18.00 Sale of medical records and abstracts	B	-115,919	MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)	B	-4,681,687	NURSING SCHOOL	20.00		0 19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0 19.01
20.00 Vending machines	B	-28,019	DIETARY	10.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

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

Worksheet A-8

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
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-BUTLER BUILDING			0	CAP REL COSTS-BUTLER BUILDING	1.01	0 26.01
26.02 Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES			0	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0 26.02
26.03 Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES			0	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0 26.03
26.04 Depreciation - CAP REL COSTS-MOB PHASE I			0	CAP REL COSTS-MOB PHASE I	1.04	0 26.04
26.05 Depreciation - CAP REL COSTS-BBC			0	CAP REL COSTS-BBC	1.05	0 26.05
26.06 Depreciation - CAP REL COSTS-BEC			0	CAP REL COSTS-BEC	1.06	0 26.06
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 RENTAL INSURANCE EXPENSE	A	-10,481		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 DAMAGED GOODS	B	-17,368		ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 CHILD CARE CENTER	B	-1,963,406		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.02
33.03 BOOKKEEPING FEES	B	-141,462		ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 RADIOLOGY TUITION	B	-74,875		PARAMEDICAL PRGM-RADIOLOGY	23.01	0 33.04
33.05 PRINT SHOP	B	-89,117		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 HEALTH PROMOTIONS	B	-75,183		NURSING ADMINISTRATIVE	13.00	0 33.06
33.07 HOUSEKEEPING SERVICES	B	-369,940		HOUSEKEEPING	9.00	0 33.07
33.08 ADVERTISING	A	-884,027		ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 ADVERTISING	A	-3,973		DIETARY	10.00	0 33.09
33.10 ADVERTISING	A	-58,930		NURSING SCHOOL	20.00	0 33.10
33.11 ADVERTISING	A	-386		SUBPROVIDER - IPF	40.00	0 33.11
33.12 ADVERTISING	A	-2,445		RADIOLOGY-DIAGNOSTIC	54.00	0 33.12
33.13 ADVERTISING	A	-215		RURAL HEALTH CLINIC	88.00	0 33.13
33.14 ADVERTISING	A	-9,871		HOME HEALTH AGENCY	101.00	0 33.14
33.15 ADVERTISING	A	-19		HOSPICE	116.00	0 33.15
33.16 ADVERTISING	A	-50		FASTCARE	192.01	0 33.16
33.17 RENTAL PROPERTY EXPENSE	A	-148,698		CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11 33.17
33.18 REAL ESTATE TAXES ON RENTAL	A	106,600		MAINTENANCE & REPAIRS	6.00	0 33.18
33.19 RENTAL PROPERTY EXPENSE	A	-35,329		MAINTENANCE & REPAIRS	6.00	0 33.19
33.20 INTEREST INCOME	A	-1,837,655		CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11 33.20
33.21 INTEREST INCOME	A	-128,373		CAP REL COSTS-MVBLE EQUIP	2.00	11 33.21
33.22 INTEREST INCOME	A	-200,940		ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23 DIETARY OUTSIDE SERVICES-SALARIES	A	-44,932		DIETARY	10.00	0 33.23
33.24 DIETARY OUTSIDE SERVICES-BENEFITS	A	-13,179		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.24
33.25 PHYSICIAN RECRUITMENT	A	-216,385		ADMINISTRATIVE & GENERAL	5.00	0 33.25
33.26 LOBBYING EXPENSE	A	-49,775		ADMINISTRATIVE & GENERAL	5.00	0 33.26
33.27 TRANSFER TO PARENT	A	-10,516,784		ADMINISTRATIVE & GENERAL	5.00	0 33.27
33.28 HOSPICE PROFESSIONAL FEES	A	-33,787		HOSPICE	116.00	0 33.28
33.29 ER PHYSICIAN BENEFITS	A	-469,129		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.29
33.30 ALCOHOL RELATED EXPENSES	A	-3,000		ADMINISTRATIVE & GENERAL	5.00	0 33.30
33.31 BOOK TO MEDICARE DEPRECIATION	A	40,874		CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9 33.31
33.32 GROUND FEES	B	-66,635		MAINTENANCE & REPAIRS	6.00	0 33.32
33.33 LABORATORY TUITION	B	-27,947		PARAMEDICAL PRGM-LABORATORY	23.02	0 33.33

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

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

Worksheet A-8

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.34 CV SURGEON BENEFITS	A	-55,401	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.34
33.35 SELF-FUNDED HEALTH INSURANCE	A	-16,211,395	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.35
33.36 TRAUMA ON-CALL	A	-1,531,003	ADMINISTRATIVE & GENERAL		5.00	0 33.36
33.37 NON-HOSPITAL DEPRECIATION	A	-217,127	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.37
33.38 MISCELLANEOUS INCOME	B	-15,099	MEDICAL RECORDS & LIBRARY		16.00	0 33.38
33.39 MISCELLANEOUS INCOME	B	-78,942	ADMINISTRATIVE & GENERAL		5.00	0 33.39
33.40 MISCELLANEOUS INCOME	B	-10,960	RESPIRATORY THERAPY		65.00	0 33.40
33.41 MISCELLANEOUS INCOME	B	-2,578	ELECTROENCEPHALOGRAPHY		70.00	0 33.41
33.42 MISCELLANEOUS INCOME	B	-10,907	ADMINISTRATIVE & GENERAL		5.00	0 33.42
33.43 MISCELLANEOUS INCOME	B	-148,817	ADMINISTRATIVE & GENERAL		5.00	0 33.43
33.44 MISCELLANEOUS INCOME	B	-400,000	DIETARY		10.00	0 33.44
33.45 MISCELLANEOUS INCOME	B	-1,938	LABORATORY		60.00	0 33.45
33.46 MISCELLANEOUS INCOME	B	-14,171	DRUGS CHARGED TO PATIENTS		73.00	0 33.46
33.47 MISCELLANEOUS INCOME	B	-1,478	ELECTROCARDIOLOGY		69.00	0 33.47
33.48 MISCELLANEOUS INCOME	B	-15,137	RADIOLOGY-DIAGNOSTIC		54.00	0 33.48
33.49 MISCELLANEOUS INCOME	B	-40	HOME HEALTH AGENCY		101.00	0 33.49
33.50 DOCTORS LOUNGE REVENUE	B	-83,780	DIETARY		10.00	0 33.50
33.51 CARE COORDINATION	B	-43,009	ADMINISTRATIVE & GENERAL		5.00	0 33.51
33.52 MISCELLANEOUS INCOME	B	-454,645	ADMINISTRATIVE & GENERAL		5.00	0 33.52
33.53 MISCELLANEOUS INCOME	B	-24,862	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 33.53
33.54 OUTSIDE CATERING	B	-23,847	DIETARY		10.00	0 33.54
33.55 BH JAVA	B	-455,044	DIETARY		10.00	0 33.55
33.56 BPS EXPENSES	A	-31,375,021	ADMINISTRATIVE & GENERAL		5.00	0 33.56
33.57 ECHO OUTREACH SALARIES	A	-5,570	ELECTROCARDIOLOGY		69.00	0 33.57
33.58 ECHO OUTREACH BENEFITS	A	-1,634	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.58
33.59 PHARMACY COVERAGE SALARIES	A	-75,304	DRUGS CHARGED TO PATIENTS		73.00	0 33.59
33.60 PHARMACY COVERAGE BENEFITS	A	-20,015	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.60
33.61 PHARMACY COVERAGE EXPENSES	A	-33,427	DRUGS CHARGED TO PATIENTS		73.00	0 33.61
33.62 INFORMATION SYSTEMS-WAGES	A	-6,568,084	ADMINISTRATIVE & GENERAL		5.00	0 33.62
33.64 INFORMATION SYSTEMS-EXPENSES	A	-9,365,949	ADMINISTRATIVE & GENERAL		5.00	0 33.64
33.65 INTEREST FROM INSURANCE	B	-1,264,017	ADMINISTRATIVE & GENERAL		5.00	0 33.65
33.66 PAIN MGMT-NP SALARIES	A	-112,458	OPERATING ROOM		50.00	0 33.66
33.67 PAIN MGMT-NP BENEFITS	A	-32,984	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.67
33.68 PAIN MGMT-NP EXPENSES	A	-3,569	OPERATING ROOM		50.00	0 33.68
33.69 PA AND NP IN EMERGENCY DEPT	A	-535,374	EMERGENCY		91.00	0 33.69
33.70 PA AND NP IN ADULTS AND PEDI	A	-448,841	ADULTS & PEDIATRICS		30.00	0 33.70
33.71 PA AND NP BENEFITS	A	-157,025	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.71
33.72 COLLEGE OF NURSING LOBBYING	A	-60,000	NURSING SCHOOL		20.00	0 33.72
33.73 LOBBYING EXPENSE	A	-2,762	SUBPROVIDER - IRF		41.00	0 33.73
33.74 HIM SALARIES	A	-3,638,709	MEDICAL RECORDS & LIBRARY		16.00	0 33.74
33.75 PFS AND PT ACCESS SALARIES	A	-5,392,399	ADMINISTRATIVE & GENERAL		5.00	0 33.75
33.76 HIM EXPENSES	A	-926,116	MEDICAL RECORDS & LIBRARY		16.00	0 33.76
33.77 PFS AND PT ACCESS EXPENSES	A	-3,609,650	ADMINISTRATIVE & GENERAL		5.00	0 33.77
33.78 DECISION SUPPORT SALARIES	A	-730,432	ADMINISTRATIVE & GENERAL		5.00	0 33.78
33.79 DECISION SUPPORT EXPENSES	A	-112,636	ADMINISTRATIVE & GENERAL		5.00	0 33.79
33.80 HUMAN RESOURCES SALARIES	A	-802,671	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.80
33.81 HUMAN RESOURCES EXPENSES	A	-842,475	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.81
33.82 MISCELLANEOUS INCOME	B	-132,719	DRUGS CHARGED TO PATIENTS		73.00	0 33.82
33.83 MISCELLANEOUS INCOME	B	-600	OPERATING ROOM		50.00	0 33.83
33.84 MISCELLANEOUS INCOME	B	-5,000	PARAMEDICAL PRGM-PHARMACY		23.03	0 33.84
33.85 MISCELLANEOUS INCOME	B	-17,000	MAINTENANCE & REPAIRS		6.00	0 33.85
33.86 HOSPICE RESPIRE AND INPATIENT PMT	A	540	HOSPICE		116.00	0 33.86
33.87 HOSPITAL SERVICES TO HOSPICE PTS	A	121,309	HOSPICE		116.00	0 33.87
33.88 ONCOLOGIST BENEFITS	A	-132,788	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.88
33.89 HOSPITALIST BENEFITS	A	-113,574	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.89
33.90 DEPRECIATION ADJUSTMENT	A	9,363	CAP REL COSTS-BUTLER BUILDING		1.01	9 33.90
33.91 DEPRECIATION ADJUSTMENT	A	-4,351,476	CAP REL COSTS-OLD BLDG & FIXTURES		1.02	9 33.91
33.92 DEPRECIATION ADJUSTMENT	A	5,353,317	CAP REL COSTS-NEW BLDG & FIXTURES		1.03	9 33.92
33.93 DEPRECIATION ADJUSTMENT	A	378,397	CAP REL COSTS-BBC		1.05	9 33.93
33.94 DEPRECIATION ADJUSTMENT	A	373,766	CAP REL COSTS-BEC		1.06	9 33.94
33.95 DEPRECIATION ADJUSTMENT	A	3,076,295	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.95
33.96 DEPRECIATION ADJUSTMENT	A	-635,177	CAP REL COSTS-NEW BLDG & FIXTURES		1.03	9 33.96

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

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

Worksheet A-8

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.97 WELLNESS CENTER RENT	A	297,400	ADMINISTRATIVE & GENERAL	5.00	0	33.97
33.98 AMORTIZATION	A	-9,332,371	ADMINISTRATIVE & GENERAL	5.00	0	33.98
34.00 CORPORATE FEES-BPS	B	-121,258	ADMINISTRATIVE & GENERAL	5.00	0	34.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-129,209,056				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0015

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

Worksheet A-8-1

Date/Time Prepared:  
2/27/2019 12:28 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED MAINTENANCE	590,624	1,204,129	1.00
2.00	50.00	OPERATING ROOM	BIO-MED MAINTENANCE	6,350	12,946	2.00
3.00	53.00	ANESTHESIOLOGY	BIO-MED MAINTENANCE	1,072	2,185	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED MAINTENANCE	324	660	4.00
4.01	69.00	ELECTROCARDIOLOGY	BIO-MED MAINTENANCE	125	255	4.01
4.02	71.00	MEDICAL SUPPLIES CHARGED TO	BIO-MED MAINTENANCE	1,414	2,882	4.02
4.03	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,212,705	1,209,922	4.03
4.04	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	79,654	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	37,052,696	17,446,447	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5,876,986	0	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	7,706,009	4.07
4.08	1.04	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	11,548	55,302	4.08
4.09	10.00	DIETARY	DIETICIAN COSTS	0	3,871	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	1,135	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	5,152	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	1,511	4.12
4.13	13.00	NURSING ADMINISTRATION	INFORMATICS/CARE MGMT COSTS	0	178,538	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	INFORMATICS/CARE MGMT BENEFIT	0	52,365	4.14
4.15	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY WAGES	0	21,412	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDY BENEFITS	0	6,280	4.16
4.17	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY EXPENSES	0	3,817	4.17
4.18	30.00	ADULTS & PEDIATRICS	TELEMETRY WAGES	0	21,718	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	6,370	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	CARE COORDINATION-IRHC	0	47,376	4.20
4.21	4.00	EMPLOYEE BENEFITS DEPARTMENT	CARE COORDINATION-IRHC BENEFIT	0	13,895	4.21
4.22	71.00	MEDICAL SUPPLIES CHARGED TO	PURCHASING AGENT WAGES	0	47,338	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING AGENT BENEFITS	0	13,884	4.23
4.24	1.05	CAP REL COSTS-BBC	BBC RENT FOR HIM PFS PA	0	159,727	4.24
4.25	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	0	11,929	4.25
4.26	0.00			0	0	4.26
4.27	0.00			0	0	4.27
4.28	0.00			0	0	4.28
4.29	0.00			0	0	4.29
4.30	0.00			0	0	4.30
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			44,785,807	28,316,709	5.00

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

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

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

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

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify: BROTHER/SISTER					100.00

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

Provider CCN: 14-0015

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

Worksheet A-8-1

Date/Time Prepared:  
2/27/2019 12:28 am

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

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

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

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

Provider CCN: 14-0015

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

Worksheet A-8-1

Date/Time Prepared:  
2/27/2019 12:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-613,505	0		1.00
2.00	-6,596	0		2.00
3.00	-1,113	0		3.00
4.00	-336	0		4.00
4.01	-130	0		4.01
4.02	-1,468	0		4.02
4.03	2,783	0		4.03
4.04	-47,691	0		4.04
4.05	19,606,249	0		4.05
4.06	5,876,986	0		4.06
4.07	-7,706,009	0		4.07
4.08	-43,754	10		4.08
4.09	-3,871	0		4.09
4.10	-1,135	0		4.10
4.11	-5,152	0		4.11
4.12	-1,511	0		4.12
4.13	-178,538	0		4.13
4.14	-52,365	0		4.14
4.15	-21,412	0		4.15
4.16	-6,280	0		4.16
4.17	-3,817	0		4.17
4.18	-21,718	0		4.18
4.19	-6,370	0		4.19
4.20	-47,376	0		4.20
4.21	-13,895	0		4.21
4.22	-47,338	0		4.22
4.23	-13,884	0		4.23
4.24	-159,727	10		4.24
4.25	-11,929	9		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
5.00	16,469,098			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

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

Worksheet A-8-2

Date/Time Prepared:  
2/27/2019 12:28 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	2,764,056	2,417,823	346,233	211,500	2,236	1.00
2.00	30.00 ADULTS & PEDIATRICS	1,359,116	1,359,116	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	1,522,494	1,522,494	0	0	0	3.00
4.00	30.00 ADULTS & PEDIATRICS	30,095	0	30,095	211,500	216	4.00
5.00	30.00 ADULTS & PEDIATRICS	35,925	0	35,925	211,500	235	5.00
6.00	31.00 INTENSIVE CARE UNIT	1,239,726	1,239,726	0	0	0	6.00
7.00	31.00 INTENSIVE CARE UNIT	101,640	101,640	0	0	0	7.00
8.00	40.00 SUBPROVIDER - IPF	7,290	0	7,290	181,300	41	8.00
9.00	41.00 SUBPROVIDER - IRF	36,000	0	36,000	211,500	288	9.00
10.00	44.00 SKILLED NURSING FACILITY	1,500	0	1,500	211,500	10	10.00
11.00	50.00 OPERATING ROOM	24,000	0	24,000	211,500	120	11.00
12.00	65.00 RESPIRATORY THERAPY	10,950	0	10,950	211,500	73	12.00
13.00	65.00 RESPIRATORY THERAPY	7,200	0	7,200	211,500	48	13.00
14.00	70.00 ELECTROENCEPHALOGRAPHY	10,725	0	10,725	211,500	72	14.00
15.00	69.00 ELECTROCARDIOLOGY	6,933	0	6,933	211,500	53	15.00
16.00	69.00 ELECTROCARDIOLOGY	4,125	0	4,125	246,400	28	16.00
17.00	70.00 ELECTROENCEPHALOGRAPHY	375	0	375	211,500	3	17.00
18.00	91.00 EMERGENCY	31,200	0	31,200	211,500	240	18.00
19.00	91.00 EMERGENCY	194,410	126,410	68,000	211,500	716	19.00
20.00	91.00 EMERGENCY	6,621,728	6,621,728	0	0	0	20.00
21.00	91.00 EMERGENCY	135,181	0	135,181	211,500	833	21.00
22.00	50.00 OPERATING ROOM	7,163	0	7,163	211,500	48	22.00
23.00	50.00 OPERATING ROOM	42,675	0	42,675	246,400	96	23.00
24.00	5.00 ADMINISTRATIVE & GENERAL	11,908,299	11,908,299	0	0	0	24.00
25.00	54.00 RADIOLOGY-DIAGNOSTIC	1,234,398	1,234,398	0	0	0	25.00
26.00	50.00 OPERATING ROOM	539,404	539,404	0	0	0	26.00
27.00	50.00 OPERATING ROOM	859,679	859,679	0	0	0	27.00
200.00		28,736,287	27,930,717	805,570		5,356	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	5.00 ADMINISTRATIVE & GENERAL	227,363	11,368	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00 ADULTS & PEDIATRICS	21,963	1,098	0	0	0	4.00
5.00	30.00 ADULTS & PEDIATRICS	23,895	1,195	0	0	0	5.00
6.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	40.00 SUBPROVIDER - IPF	3,574	179	0	0	0	8.00
9.00	41.00 SUBPROVIDER - IRF	29,285	1,464	0	0	0	9.00
10.00	44.00 SKILLED NURSING FACILITY	1,017	51	0	0	0	10.00
11.00	50.00 OPERATING ROOM	12,202	610	0	0	0	11.00
12.00	65.00 RESPIRATORY THERAPY	7,423	371	0	0	0	12.00
13.00	65.00 RESPIRATORY THERAPY	4,881	244	0	0	0	13.00
14.00	70.00 ELECTROENCEPHALOGRAPHY	7,321	366	0	0	0	14.00
15.00	69.00 ELECTROCARDIOLOGY	5,389	269	0	0	0	15.00
16.00	69.00 ELECTROCARDIOLOGY	3,317	166	0	0	0	16.00
17.00	70.00 ELECTROENCEPHALOGRAPHY	305	15	0	0	0	17.00
18.00	91.00 EMERGENCY	24,404	1,220	0	0	0	18.00
19.00	91.00 EMERGENCY	72,805	3,640	0	0	0	19.00
20.00	91.00 EMERGENCY	0	0	0	0	0	20.00
21.00	91.00 EMERGENCY	84,702	4,235	0	0	0	21.00
22.00	50.00 OPERATING ROOM	4,881	244	0	0	0	22.00
23.00	50.00 OPERATING ROOM	11,372	569	0	0	0	23.00
24.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	24.00
25.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	25.00
26.00	50.00 OPERATING ROOM	0	0	0	0	0	26.00
27.00	50.00 OPERATING ROOM	0	0	0	0	0	27.00
200.00		546,099	27,304	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	5.00 ADMINISTRATIVE & GENERAL	0	227,363	118,870	2,536,693	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	1,359,116	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	0	0	1,522,494	3.00
4.00	30.00 ADULTS & PEDIATRICS	0	21,963	8,132	8,132	4.00
5.00	30.00 ADULTS & PEDIATRICS	0	23,895	12,030	12,030	5.00
6.00	31.00 INTENSIVE CARE UNIT	0	0	0	1,239,726	6.00
7.00	31.00 INTENSIVE CARE UNIT	0	0	0	101,640	7.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

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

Worksheet A-8-2

Date/Time Prepared:  
2/27/2019 12:28 am

	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		
8.00	40.00	SUBPROVIDER - IPF	0	3,574	3,716	3,716		8.00
9.00	41.00	SUBPROVIDER - IRF	0	29,285	6,715	6,715		9.00
10.00	44.00	SKILLED NURSING FACILITY	0	1,017	483	483		10.00
11.00	50.00	OPERATING ROOM	0	12,202	11,798	11,798		11.00
12.00	65.00	RESPIRATORY THERAPY	0	7,423	3,527	3,527		12.00
13.00	65.00	RESPIRATORY THERAPY	0	4,881	2,319	2,319		13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,321	3,404	3,404		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	5,389	1,544	1,544		15.00
16.00	69.00	ELECTROCARDIOLOGY	0	3,317	808	808		16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	0	305	70	70		17.00
18.00	91.00	EMERGENCY	0	24,404	6,796	6,796		18.00
19.00	91.00	EMERGENCY	0	72,805	0	126,410		19.00
20.00	91.00	EMERGENCY	0	0	0	6,621,728		20.00
21.00	91.00	EMERGENCY	0	84,702	50,479	50,479		21.00
22.00	50.00	OPERATING ROOM	0	4,881	2,282	2,282		22.00
23.00	50.00	OPERATING ROOM	0	11,372	31,303	31,303		23.00
24.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,908,299		24.00
25.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,234,398		25.00
26.00	50.00	OPERATING ROOM	0	0	0	539,404		26.00
27.00	50.00	OPERATING ROOM	0	0	0	859,679		27.00
200.00			0	546,099	264,276	28,194,993		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
		0	1.00	1.01	1.02	1.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	36,063	0	36,063		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	436,133	0	0	436,133	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	6,327,898	0	0	0	6,327,898
1.04	00104	CAP REL COSTS-MOB PHASE I	48,417	0	0	0	0
1.05	00105	CAP REL COSTS-BBC	460,681	0	0	0	0
1.06	00106	CAP REL COSTS-BEC	493,063	0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,618,044				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,677,433	0	0	16,400	57,325
5.00	00500	ADMINISTRATIVE & GENERAL	54,285,247	0	709	99,179	1,181,088
6.00	00600	MAINTENANCE & REPAIRS	7,845,786	0	7,166	69,063	733,991
8.00	00800	LAUNDRY & LINEN SERVICE	1,270,610	0	0	6,522	14,681
9.00	00900	HOUSEKEEPING	3,308,438	0	0	15,535	11,057
10.00	01000	DIETARY	1,420,212	0	0	279	150,213
11.00	01100	CAFETERIA	2,556,145	0	0	0	70,049
13.00	01300	NURSING ADMINISTRATION	7,648,482	0	0	15,077	8,769
16.00	01600	MEDICAL RECORDS & LIBRARY	5,745,968	0	0	2,162	36,836
20.00	02000	NURSING SCHOOL	1,795,247	0	24,802	0	217,093
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,110,470	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,951,903	0	0	0	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	226,944	0	0	0	5,342
23.02	02302	PARAMED ED PRGM-LABORATORY	44,679	0	0	0	5,342
23.03	02303	PARAMED ED PRGM-PHARMACY	307,258	0	0	0	0
23.04	02304	PARAMED ED PRGM-RESPIRATORY	191,654	0	0	0	3,913
23.05	02305	PARAMED ED PRGM-HIM	49,936	0	0	0	1,553
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	20,752,603	0	0	2,649	1,360,924
31.00	03100	INTENSIVE CARE UNIT	4,455,173	0	0	35,974	118,801
40.00	04000	SUBPROVIDER - I/PF	4,351,246	0	0	0	375,423
41.00	04100	SUBPROVIDER - I/RF	1,715,335	0	0	17,486	54,675
43.00	04300	NURSERY	379,177	0	0	0	36,929
44.00	04400	SKILLED NURSING FACILITY	1,732,552	0	0	0	122,974
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	14,384,668	0	0	38,570	294,617
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,448,873	0	0	26,936	14,360
53.00	05300	ANESTHESIOLOGY	573,868	0	0	2,215	7,019
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,448,520	0	0	5,383	164,086
55.00	05500	RADIOLOGY-THERAPEUTIC	1,560,501	0	0	0	134,548
57.00	05700	CT SCAN	838,573	0	0	2,120	10,270
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	638,048	0	0	0	21,172
60.00	06000	LABORATORY	6,827,200	0	0	2,349	109,504
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,509,248	0	0	0	3,986
65.00	06500	RESPIRATORY THERAPY	2,400,975	0	0	6,999	0
66.00	06600	PHYSICAL THERAPY	1,404,449	0	0	0	35,366
67.00	06700	OCCUPATIONAL THERAPY	751,844	0	0	0	17,000
68.00	06800	SPEECH PATHOLOGY	230,972	0	0	0	5,756
69.00	06900	ELECTROCARDIOLOGY	2,807,957	0	0	29,081	47,614
70.00	07000	ELECTROENCEPHALOGRAPHY	519,531	0	0	6,992	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,667,605	0	1,346	0	61,373
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,762,495	0	2,040	0	93,053
73.00	07300	DRUGS CHARGED TO PATIENTS	18,329,485	0	0	1,094	40,211
74.00	07400	RENAL DIALYSIS	865,525	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	937,330	0	0	0	0
90.00	09000	CLINIC	512,934	0	0	0	0
90.01	04950	OUTPATIENT INFUSION	385,401	0	0	0	36,194
91.00	09100	EMERGENCY	5,855,122	0	0	19,846	156,849
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	4,287,500	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	1,555,213	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,746,634	0	36,063	421,911	5,819,956
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,367	8,231
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,259,733	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
192.01	19201	FASTCARE	235,405	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	10,353	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	1,841	244,208	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	22,269	0	0	2,014	245,150	193.05
193.06	19306	AUGUSTA PHARMACY	886,175	0	0	0	0	193.06
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)	261,150,216	0	36,063	436,133	6,327,898	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part I Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
		MOB PHASE I	BBC	BEC	MVBLE EQUIP		
		1.04	1.05	1.06	2.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	48,417				1.04
1.05	00105	CAP REL COSTS-BBC	0	460,681			1.05
1.06	00106	CAP REL COSTS-BEC	0	0	493,063		1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP				13,618,044	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				137,888	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,417	261,612	200,751	4,353,621	13,889,046
6.00	00600	MAINTENANCE & REPAIRS	0	4,499	0	341,822	1,362,404
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,114	376,127
9.00	00900	HOUSEKEEPING	0	158	0	90,605	5,210
10.00	01000	DIETARY	0	0	0	128,179	343,360
11.00	01100	CAFETERIA	0	0	0	0	124,839
13.00	01300	NURSING ADMINISTRATION	0	1,875	77,588	851,721	216,621
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,479	0	77,121	1,023,189
20.00	02000	NURSING SCHOOL	0	0	105,751	104,689	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	757	597,409
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	154,845
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	26,231	0	39,752
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,677	9,706
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	40,757
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	1,914	1,889	20,630
23.05	02305	PARAMED ED PRGM-HIM	0	0	755	752	4,609
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,420,456	2,170,873
31.00	03100	INTENSIVE CARE UNIT	0	0	0	133,001	520,363
40.00	04000	SUBPROVIDER - I PF	0	0	0	7,559	577,610
41.00	04100	SUBPROVIDER - I RF	0	0	0	18,372	202,079
43.00	04300	NURSERY	0	0	0	26,616	48,428
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,003	215,761
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	2,502,297	1,269,317
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	34,633	175,942
53.00	05300	ANESTHESIOLOGY	0	0	0	166,093	29,334
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	578,464	487,492
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	698,619	164,942
57.00	05700	CT SCAN	0	0	0	131,113	75,628
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	45,490
60.00	06000	LABORATORY	0	0	0	225,589	425,776
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	14,824	17,843
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	296,322
66.00	06600	PHYSICAL THERAPY	0	0	0	7,839	193,040
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,149	103,725
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,630	31,012
69.00	06900	ELECTROCARDIOLOGY	0	0	0	726,990	282,013
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	36,724	56,381
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,305	41,476
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	108,123	72,902
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	353,169	574,513
74.00	07400	RENAL DIALYSIS	0	0	0	7,630	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	85,059
90.00	09000	CLINIC	0	0	0	0	59,726
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	46,113
91.00	09100	EMERGENCY	0	0	42,356	182,986	519,950
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	0	37,717	3,455	440,182
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	24,794	154,355
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,417	312,623	493,063	13,585,268	13,703,105
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,871	127,595
192.01	19201	FASTCARE	0	0	0	27,533	25,985
193.00	19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			MOB PHASE I	BBC	BEC	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
193.01	19301	DENMAN SERVICES	0	0	0	286	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	6,275	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	3,096	193.04
193.05	19305	RENTED SPACE	0	141,783	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	3,086	29,265	193.06
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)	48,417	460,681	493,063	13,618,044	13,889,046	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-BBC						1.05
1.06	00106	CAP REL COSTS-BEC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,793,028	61,793,028				5.00
6.00	00600	MAINTENANCE & REPAIRS	9,378,454	2,906,955	12,285,409			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,301,137	403,302	75,006	1,779,445		8.00
9.00	00900	HOUSEKEEPING	3,769,153	1,168,290	125,998	18,014	5,081,455	9.00
10.00	01000	DIETARY	1,823,722	565,283	334,923	13,104	147,800	10.00
11.00	01100	CAFETERIA	2,842,815	881,162	155,339	0	68,541	11.00
13.00	01300	NURSING ADMINISTRATION	9,626,701	2,983,902	218,705	0	96,509	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,906,566	1,830,805	199,259	0	87,907	16.00
20.00	02000	NURSING SCHOOL	2,844,991	881,836	730,801	0	335,988	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,266,072	392,433	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,951,903	605,014	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	298,269	92,452	44,563	0	19,642	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	62,404	19,343	11,847	0	5,244	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	348,015	107,871	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	220,000	68,191	44,356	0	6,072	23.04
23.05	02305	PARAMED ED PRGM-HIM	57,605	17,855	5,464	0	2,392	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	25,707,505	7,968,397	3,035,200	595,893	1,339,219	30.00
31.00	03100	INTENSIVE CARE UNIT	5,263,312	1,631,421	497,586	99,729	219,561	31.00
40.00	04000	SUBPROVIDER - I/PF	5,311,838	1,646,463	832,532	22,072	367,361	40.00
41.00	04100	SUBPROVIDER - I/RF	2,007,947	622,385	235,052	96,762	103,731	41.00
43.00	04300	NURSERY	491,150	152,237	81,894	10,788	36,156	43.00
44.00	04400	SKILLED NURSING FACILITY	2,072,290	642,329	272,705	70,939	120,338	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	18,489,469	5,731,014	904,370	141,377	399,055	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,700,744	527,164	207,157	49,148	91,403	52.00
53.00	05300	ANESTHESIOLOGY	778,529	241,314	29,984	0	13,248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,683,945	2,071,762	398,909	131,698	175,998	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,558,610	793,069	298,372	69,415	131,654	55.00
57.00	05700	CT SCAN	1,057,704	327,847	36,573	41,758	16,146	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	704,710	218,433	46,951	9,927	20,700	58.00
60.00	06000	LABORATORY	7,590,418	2,352,734	258,126	175	113,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,545,901	479,169	8,839	0	3,910	62.00
65.00	06500	RESPIRATORY THERAPY	2,704,296	838,226	45,550	0	20,102	65.00
66.00	06600	PHYSICAL THERAPY	1,640,694	508,551	78,427	0	34,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	876,718	271,748	37,698	0	16,652	67.00
68.00	06800	SPEECH PATHOLOGY	271,370	84,114	12,765	0	5,612	68.00
69.00	06900	ELECTROCARDIOLOGY	3,893,655	1,206,881	294,860	70,681	130,090	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	619,628	192,061	45,504	538	20,056	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,843,105	3,670,901	144,319	9,326	63,711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,038,613	4,661,384	218,866	14,142	96,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,298,472	5,981,774	96,289	0	42,505	73.00
74.00	07400	RENAL DIALYSIS	873,155	270,644	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,022,389	316,901	0	0	0	88.00
90.00	09000	CLINIC	572,660	177,502	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	467,708	144,971	80,264	585	35,420	90.01
91.00	09100	EMERGENCY	6,777,109	2,100,639	529,820	307,543	233,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	4,768,854	1,478,159	47,043	0	20,746	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,734,362	537,585	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	257,857,695	60,772,473	10,721,916	1,773,614	4,642,288	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,598	5,765	85,728	5,831	37,812	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,389,199	430,598	0	0	0	192.00
192.01	19201	FASTCARE	288,923	89,555	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	10,639	3,298	22,959	0	10,120	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	252,324	78,211	568,138	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
193.04	19304	HEALTH EDUCATION	3,096	960	0	0	0	193.04
193.05	19305	RENTED SPACE	411,216	127,461	886,668	0	391,235	193.05
193.06	19306	AUGUSTA PHARMACY	918,526	284,707	0	0	0	193.06
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)	261,150,216	61,793,028	12,285,409	1,779,445	5,081,455	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part I Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-BBC						1.05
1.06	00106	CAP REL COSTS-BEC						1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,884,832					10.00
11.00	01100	CAFETERIA	0	3,947,857				11.00
13.00	01300	NURSING ADMINISTRATION	0	353,261	13,279,078			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,024,537		16.00
20.00	02000	NURSING SCHOOL	0	184,841	0	0	4,978,457	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	58,130	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	11,923	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,097	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	9,638	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	7,302	0	0	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	477	0	0	0	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,738,584	885,533	4,756,983	4,810,617	3,825,642	30.00
31.00	03100	INTENSIVE CARE UNIT	213,983	182,028	977,819	592,066	247,165	31.00
40.00	04000	SUBPROVIDER - I PF	494,761	239,955	1,288,993	1,368,991	250,531	40.00
41.00	04100	SUBPROVIDER - I RF	194,563	75,710	406,709	538,376	140,222	41.00
43.00	04300	NURSERY	0	14,502	77,914	12,095	50,355	43.00
44.00	04400	SKILLED NURSING FACILITY	242,941	91,958	493,984	672,222	41,506	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	464,017	2,492,672	0	111,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,273	313,026	0	147,078	52.00
53.00	05300	ANESTHESIOLOGY	0	14,258	76,606	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	183,216	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	47,924	0	0	0	55.00
57.00	05700	CT SCAN	0	24,069	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,096	0	0	0	58.00
60.00	06000	LABORATORY	0	198,886	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8,541	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	111,752	0	0	4,487	65.00
66.00	06600	PHYSICAL THERAPY	0	53,895	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,589	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,272	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,470	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,241	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,582	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,441	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149,683	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	20,677	0	0	10,470	90.00
90.01	04950	OUTPATIENT INFUSION	0	16,422	0	0	0	90.01
91.00	09100	EMERGENCY	0	235,111	1,262,987	30,170	128,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	788,326	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	297,053	0	20,566	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,884,832	3,946,770	13,233,072	8,024,537	4,978,457	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	46,006	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			DI ETARY	CAFETERIA	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	NURSI NG SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	1,087	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
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)	2,884,832	3,947,857	13,279,078	8,024,537	4,978,457	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03 00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04 00104	CAP REL COSTS-MOB PHASE I					1.04
1.05 00105	CAP REL COSTS-BBC					1.05
1.06 00106	CAP REL COSTS-BEC					1.06
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
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,716,635				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,556,917			22.00
23.00 02300	PARAMED PRGM			0		23.00
23.01 02301	PARAMED PRGM-RADIOLOGY				466,849	23.01
23.02 02302	PARAMED PRGM-LABORATORY					101,935
23.03 02303	PARAMED PRGM-PHARMACY					23.03
23.04 02304	PARAMED PRGM-RESPIRATORY					23.04
23.05 02305	PARAMED PRGM-HIM					23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,126,931	1,678,556	0	0	0 30.00
31.00 03100	INTENSIVE CARE UNIT	60,145	89,585	0	0	0 31.00
40.00 04000	SUBPROVIDER - I PF	50,959	75,903	0	0	0 40.00
41.00 04100	SUBPROVIDER - I RF	70,608	105,170	0	0	0 41.00
43.00 04300	NURSERY	49,681	74,000	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	77,158	114,926	0	0	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	9,185	13,682	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,013	25,341	0	466,849	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
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	13,099	19,511	0	0	101,935 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
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	43,132	64,244	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	67,972	101,244	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 04950	OUTPATIENT INFUSION	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	130,752	194,755	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE			0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,716,635	2,556,917	0	466,849	101,935 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	FASTCARE	0	0	0	0	0 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY		
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS					
			21.00	22.00					23.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments	0	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,716,635	2,556,917	0	466,849	101,935	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-BBC						1.05
1.06	00106	CAP REL COSTS-BEC						1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	465,524					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		345,921				23.04
23.05	02305	PARAMED ED PRGM-HIM			83,793			23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	50,234	57,519,294	-2,805,487	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,182	10,080,582	-149,730	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	14,295	11,964,654	-126,862	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	5,622	4,602,857	-175,778	41.00
43.00	04300	NURSERY	0	0	126	1,050,898	-123,681	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	7,019	4,728,231	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	28,925,862	-192,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,093,993	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,176,806	-22,867	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,154,731	-42,354	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,899,044	0	55.00
57.00	05700	CT SCAN	0	0	0	1,504,097	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,014,817	0	58.00
60.00	06000	LABORATORY	0	0	0	10,648,781	-32,610	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,046,360	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	345,921	0	4,070,334	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,316,159	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,233,405	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	383,133	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,793,013	-107,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,071,244	-169,216	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,758,944	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,076,001	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	465,524	0	0	26,034,247	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,143,799	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,339,290	0	88.00
90.00	09000	CLINIC	0	0	0	781,309	0	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	745,370	0	90.01
91.00	09100	EMERGENCY	0	0	315	11,931,607	-325,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	0	7,103,128	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	2,589,566	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	465,524	345,921	83,793	254,781,556	-4,273,552	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	153,734	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,819,797	0	192.00
192.01	19201	FASTCARE	0	0	0	424,484	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
193.01	19301	DENMAN SERVICES	0	0	0	47,016	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	898,673	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	5,143	0	193.04
193.05	19305	RENTED SPACE	0	0	0	1,816,580	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	1,203,233	0	193.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	465,524	345,921	83,793	261,150,216	-4,273,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part I Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-BBC	1.05
1.06	00106	CAP REL COSTS-BEC	1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	04950	OUTPATIENT INFUSION	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FASTCARE	192.01
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	MEALS ON WHEELS	193.02
193.03	19303	UNUSED SPACE	193.03
193.04	19304	HEALTH EDUCATION	193.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Total	
		26.00	
193.05	19305 RENTED SPACE	1,816,580	193.05
193.06	19306 AUGUSTA PHARMACY	1,203,233	193.06
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	256,876,664	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0015

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

Worksheet Non-CMS W  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	31	SQUARE FEET	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	32	SQUARE FEET	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	33	SQUARE FEET	1.03
1.04	CAP REL COSTS-MOB PHASE I	34	SQUARE FEET	1.04
1.05	CAP REL COSTS-BBC	35	SQUARE FEET	1.05
1.06	CAP REL COSTS-BEC	36	SQUARE FEET	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
20.00	NURSING SCHOOL	20	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	21	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
			BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES		
		0	1.00	1.01	1.02	1.03		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04	
1.05	00105	CAP REL COSTS-BBC					1.05	
1.06	00106	CAP REL COSTS-BEC					1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,228	0	0	16,400	57,325	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,108,619	0	709	99,179	1,181,088	5.00
6.00	00600	MAINTENANCE & REPAIRS	811	0	7,166	69,063	733,991	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,522	14,681	8.00
9.00	00900	HOUSEKEEPING	0	0	0	15,535	11,057	9.00
10.00	01000	DIETARY	78,831	0	0	279	150,213	10.00
11.00	01100	CAFETERIA	0	0	0	0	70,049	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	15,077	8,769	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,162	36,836	16.00
20.00	02000	NURSING SCHOOL	0	0	24,802	0	217,093	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	0	0	0	0	5,342	23.01
23.02	02302	PARAMED PRGM-LABORATORY	0	0	0	0	5,342	23.02
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED PRGM-RESPIRATORY	0	0	0	0	3,913	23.04
23.05	02305	PARAMED PRGM-HIM	0	0	0	0	1,553	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	72,300	0	0	2,649	1,360,924	30.00
31.00	03100	INTENSIVE CARE UNIT	16,757	0	0	35,974	118,801	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	375,423	40.00
41.00	04100	SUBPROVIDER - IRF	2,205	0	0	17,486	54,675	41.00
43.00	04300	NURSERY	0	0	0	0	36,929	43.00
44.00	04400	SKILLED NURSING FACILITY	4,915	0	0	0	122,974	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,038,166	0	0	38,570	294,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,936	14,360	52.00
53.00	05300	ANESTHESIOLOGY	18,204	0	0	2,215	7,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	430,549	0	0	5,383	164,086	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	134,548	55.00
57.00	05700	CT SCAN	0	0	0	2,120	10,270	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	21,172	58.00
60.00	06000	LABORATORY	160,899	0	0	2,349	109,504	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	3,986	62.00
65.00	06500	RESPIRATORY THERAPY	98,799	0	0	6,999	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	35,366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	17,000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	5,756	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,081	47,614	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	68,211	0	0	6,992	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,091	0	1,346	0	61,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	156,323	0	2,040	0	93,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,094	40,211	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	32,297	0	0	0	0	88.00
90.00	09000	CLINIC	68,247	0	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	36,194	90.01
91.00	09100	EMERGENCY	0	0	0	19,846	156,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	2,078	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	96,782	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,577,312	0	36,063	421,911	5,819,956	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,367	8,231	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	35,020	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
				1.00	1.01	1.02	1.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	10,353	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	1,841	244,208	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	2,014	245,150	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
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)	3,612,332	0	36,063	436,133	6,327,898	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		CAPITAL RELATED COSTS				Subtotal 2A		
		MOB PHASE I	BBC	BEC	MVBLE EQUIP			
		1.04	1.05	1.06	2.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04	
1.05	00105	CAP REL COSTS-BBC					1.05	
1.06	00106	CAP REL COSTS-BEC					1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	137,888	230,841	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,417	261,612	200,751	4,353,621	7,253,996	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	4,499	0	341,822	1,157,352	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,114	25,317	8.00
9.00	00900	HOUSEKEEPING	0	158	0	90,605	117,355	9.00
10.00	01000	DIETARY	0	0	0	128,179	357,502	10.00
11.00	01100	CAFETERIA	0	0	0	0	70,049	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,875	77,588	851,721	955,030	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,479	0	77,121	160,598	16.00
20.00	02000	NURSING SCHOOL	0	0	105,751	104,689	452,335	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	757	757	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	0	0	26,231	0	31,573	23.01
23.02	02302	PARAMED PRGM-LABORATORY	0	0	0	2,677	8,019	23.02
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED PRGM-RESPIRATORY	0	0	1,914	1,889	7,716	23.04
23.05	02305	PARAMED PRGM-HIM	0	0	755	752	3,060	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,420,456	2,856,329	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	133,001	304,533	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	7,559	382,982	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	18,372	92,738	41.00
43.00	04300	NURSERY	0	0	0	26,616	63,545	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,003	128,892	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	2,502,297	3,873,650	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	34,633	75,929	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	166,093	193,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	578,464	1,178,482	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	698,619	833,167	55.00
57.00	05700	CT SCAN	0	0	0	131,113	143,503	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	21,172	58.00
60.00	06000	LABORATORY	0	0	0	225,589	498,341	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	14,824	18,810	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	105,798	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,839	43,205	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,149	21,149	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,630	9,386	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	726,990	803,685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	36,724	111,927	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,305	237,115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	108,123	359,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	353,169	394,474	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,630	7,630	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	32,297	88.00
90.00	09000	CLINIC	0	0	0	0	68,247	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	36,194	90.01
91.00	09100	EMERGENCY	0	0	42,356	182,986	402,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	37,717	3,455	43,250	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	24,794	121,576	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,417	312,623	493,063	13,585,268	24,294,613	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	18,598	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,871	1,871	192.00
192.01	19201	FASTCARE	0	0	0	27,533	62,553	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	286	10,639	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			CAPITAL RELATED COSTS				Subtotal	
			MOB PHASE I	BBC	BEC	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
193.03	19303	UNUSED SPACE	0	6,275	0	0	252,324	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	141,783	0	0	388,947	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	3,086	3,086	193.06
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)	48,417	460,681	493,063	13,618,044	25,032,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-BBC						1.05
1.06	00106	CAP REL COSTS-BEC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	230,841					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,648	7,276,644				5.00
6.00	00600	MAINTENANCE & REPAIRS	6,253	342,323	1,505,928			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	87	47,493	9,194	82,091		8.00
9.00	00900	HOUSEKEEPING	5,708	137,578	15,445	831	276,917	9.00
10.00	01000	DIETARY	2,075	66,568	41,054	605	8,054	10.00
11.00	01100	CAFETERIA	3,601	103,766	19,041	0	3,735	11.00
13.00	01300	NURSING ADMINISTRATION	17,009	351,384	26,809	0	5,259	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	215,596	24,425	0	4,791	16.00
20.00	02000	NURSING SCHOOL	9,931	103,845	89,581	0	18,310	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,574	46,213	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	71,246	0	0	0	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	661	10,887	5,462	0	1,070	23.01
23.02	02302	PARAMED PRGM-LABORATORY	161	2,278	1,452	0	286	23.02
23.03	02303	PARAMED PRGM-PHARMACY	678	12,703	0	0	0	23.03
23.04	02304	PARAMED PRGM-RESPIRATORY	343	8,030	5,437	0	331	23.04
23.05	02305	PARAMED PRGM-HIM	77	2,103	670	0	130	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	36,043	938,256	372,053	27,490	72,981	30.00
31.00	03100	INTENSIVE CARE UNIT	8,650	192,116	60,993	4,601	11,965	31.00
40.00	04000	SUBPROVIDER - IPF	9,602	193,887	102,051	1,018	20,020	40.00
41.00	04100	SUBPROVIDER - IRF	3,359	73,292	28,812	4,464	5,653	41.00
43.00	04300	NURSERY	805	17,927	10,038	498	1,970	43.00
44.00	04400	SKILLED NURSING FACILITY	3,587	75,641	33,428	3,273	6,558	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	21,101	674,884	110,856	6,522	21,747	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,925	62,079	25,393	2,267	4,981	52.00
53.00	05300	ANESTHESIOLOGY	488	28,417	3,675	0	722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,104	243,971	48,898	6,076	9,591	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,742	93,392	36,574	3,202	7,175	55.00
57.00	05700	CT SCAN	1,257	38,607	4,483	1,926	880	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	756	25,723	5,755	458	1,128	58.00
60.00	06000	LABORATORY	7,078	277,058	31,641	8	6,207	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	297	56,427	1,083	0	213	62.00
65.00	06500	RESPIRATORY THERAPY	4,926	98,710	5,583	0	1,095	65.00
66.00	06600	PHYSICAL THERAPY	3,209	59,887	9,613	0	1,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,724	32,001	4,621	0	907	67.00
68.00	06800	SPEECH PATHOLOGY	516	9,905	1,565	0	306	68.00
69.00	06900	ELECTROCARDIOLOGY	4,688	142,122	36,143	3,261	7,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	937	22,617	5,578	25	1,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	689	432,285	17,690	430	3,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,212	548,924	26,828	652	5,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,550	704,414	11,803	0	2,316	73.00
74.00	07400	RENAL DIALYSIS	0	31,871	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,414	37,318	0	0	0	88.00
90.00	09000	CLINIC	993	20,903	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	767	17,072	9,839	27	1,930	90.01
91.00	09100	EMERGENCY	8,643	247,371	64,945	14,188	12,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	7,317	174,068	5,766	0	1,131	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,566	63,306	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,751	7,156,464	1,314,277	81,822	252,983	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	679	10,508	269	2,061	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,121	50,707	0	0	0	192.00
192.01	19201	FASTCARE	432	10,546	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	388	2,814	0	552	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
193.03	19303	UNUSED SPACE	0	9,210	69,642	0	0	193.03
193.04	19304	HEALTH EDUCATION	51	113	0	0	0	193.04
193.05	19305	RENTED SPACE	0	15,010	108,687	0	21,321	193.05
193.06	19306	AUGUSTA PHARMACY	486	33,527	0	0	0	193.06
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)	230,841	7,276,644	1,505,928	82,091	276,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-BBC						1.05
1.06	00106	CAP REL COSTS-BEC						1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	475,858					10.00
11.00	01100	CAFETERIA	0	200,192				11.00
13.00	01300	NURSING ADMINISTRATION	0	17,914	1,373,405			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	405,410		16.00
20.00	02000	NURSING SCHOOL	0	9,373	0	0	683,375	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,948	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	605	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	157	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	489	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	370	0	0	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	24	0	0	0	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	286,782	44,906	491,997	243,039		30.00
31.00	03100	INTENSIVE CARE UNIT	35,297	9,230	101,132	29,912		31.00
40.00	04000	SUBPROVIDER - I PF	81,612	12,168	133,316	69,163		40.00
41.00	04100	SUBPROVIDER - I RF	32,093	3,839	42,064	27,199		41.00
43.00	04300	NURSERY	0	735	8,058	611		43.00
44.00	04400	SKILLED NURSING FACILITY	40,074	4,663	51,091	33,962		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	23,530	257,808	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,955	32,375	0		52.00
53.00	05300	ANESTHESIOLOGY	0	723	7,923	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,291	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,430	0	0		55.00
57.00	05700	CT SCAN	0	1,220	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	715	0	0		58.00
60.00	06000	LABORATORY	0	10,085	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	433	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	5,667	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,733	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,551	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	470	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,537	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,229	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,399	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,355	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,590	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	1,048	0	0		90.00
90.01	04950	OUTPATIENT INFUSION	0	833	0	0		90.01
91.00	09100	EMERGENCY	0	11,922	130,626	1,524		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	81,534	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0		113.00
116.00	11600	HOSPICE	0	0	30,723	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	475,858	200,137	1,368,647	405,410	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	FASTCARE	0	0	4,758	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	DENMAN SERVICES	0	0	0	0		193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0		193.02

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			DI ETARY	CAFETERIA	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	NURSI NG SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.03	19303	UNUSED SPACE	0	0	0	0		193.03
193.04	19304	HEALTH EDUCATION	0	55	0	0		193.04
193.05	19305	RENTED SPACE	0	0	0	0		193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0		193.06
200.00		Cross Foot Adjustments					683,375	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	475,858	200,192	1,373,405	405,410	683,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03 00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04 00104	CAP REL COSTS-MOB PHASE I					1.04
1.05 00105	CAP REL COSTS-BBC					1.05
1.06 00106	CAP REL COSTS-BEC					1.06
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
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	52,492				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		71,246			22.00
23.00 02300	PARAMED ED PRGM			0		23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY				50,258	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY					12,353
23.03 02303	PARAMED ED PRGM-PHARMACY					23.03
23.04 02304	PARAMED ED PRGM-RESPIRATORY					23.04
23.05 02305	PARAMED ED PRGM-HIM					23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS					30.00
31.00 03100	INTENSIVE CARE UNIT					31.00
40.00 04000	SUBPROVIDER - IPF					40.00
41.00 04100	SUBPROVIDER - IRF					41.00
43.00 04300	NURSERY					43.00
44.00 04400	SKILLED NURSING FACILITY					44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM					50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM					52.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
55.00 05500	RADIOLOGY-THERAPEUTIC					55.00
57.00 05700	CT SCAN					57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)					58.00
60.00 06000	LABORATORY					60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS					62.00
65.00 06500	RESPIRATORY THERAPY					65.00
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
68.00 06800	SPEECH PATHOLOGY					68.00
69.00 06900	ELECTROCARDIOLOGY					69.00
70.00 07000	ELECTROENCEPHALOGRAPHY					70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
74.00 07400	RENAL DIALYSIS					74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC					88.00
90.00 09000	CLINIC					90.00
90.01 04950	OUTPATIENT INFUSION					90.01
91.00 09100	EMERGENCY					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY					101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE					116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES					192.00
192.01 19201	FASTCARE					192.01
193.00 19300	NONPAID WORKERS					193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.01	19301	DENMAN SERVICES						193.01
193.02	19302	MEALS ON WHEELS						193.02
193.03	19303	UNUSED SPACE						193.03
193.04	19304	HEALTH EDUCATION						193.04
193.05	19305	RENTED SPACE						193.05
193.06	19306	AUGUSTA PHARMACY						193.06
200.00		Cross Foot Adjustments	52,492	71,246	0	50,258	12,353	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,492	71,246	0	50,258	12,353	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
			23.03	23.04	23.05	24.00	25.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-BBC					1.05
1.06	00106	CAP REL COSTS-BEC					1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM					23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	13,870				23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		22,227			23.04
23.05	02305	PARAMED ED PRGM-HIM			6,064		23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS				5,369,876	0 30.00
31.00	03100	INTENSIVE CARE UNIT				758,429	0 31.00
40.00	04000	SUBPROVIDER - IPF				1,005,819	0 40.00
41.00	04100	SUBPROVIDER - IRF				313,513	0 41.00
43.00	04300	NURSERY				104,187	0 43.00
44.00	04400	SKILLED NURSING FACILITY				381,169	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM				4,990,098	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				208,904	0 52.00
53.00	05300	ANESTHESIOLOGY				235,479	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,504,413	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				978,682	0 55.00
57.00	05700	CT SCAN				191,876	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)				55,707	0 58.00
60.00	06000	LABORATORY				830,418	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				77,263	0 62.00
65.00	06500	RESPIRATORY THERAPY				221,779	0 65.00
66.00	06600	PHYSICAL THERAPY				120,532	0 66.00
67.00	06700	OCCUPATIONAL THERAPY				61,953	0 67.00
68.00	06800	SPEECH PATHOLOGY				22,148	0 68.00
69.00	06900	ELECTROCARDIOLOGY				1,001,525	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				143,406	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				693,080	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				944,772	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,130,147	0 73.00
74.00	07400	RENAL DIALYSIS				39,501	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC				71,029	0 88.00
90.00	09000	CLINIC				91,191	0 90.00
90.01	04950	OUTPATIENT INFUSION				66,662	0 90.01
91.00	09100	EMERGENCY				893,996	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY				313,066	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE				218,171	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	23,038,791	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				32,115	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				54,699	0 192.00
192.01	19201	FASTCARE				78,289	0 192.01
193.00	19300	NONPAID WORKERS				0	0 193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
			23.03	23.04	23.05	24.00	25.00
193.01	19301	DENMAN SERVICES				14,393	0
193.02	19302	MEALS ON WHEELS				0	0
193.03	19303	UNUSED SPACE				331,176	0
193.04	19304	HEALTH EDUCATION				219	0
193.05	19305	RENTED SPACE				533,965	0
193.06	19306	AUGUSTA PHARMACY				37,099	0
200.00		Cross Foot Adjustments	13,870	22,227	6,064	911,885	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	13,870	22,227	6,064	25,032,631	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-BBC	1.05
1.06	00106	CAP REL COSTS-BEC	1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	04950	OUTPATIENT INFUSION	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FASTCARE	192.01
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	MEALS ON WHEELS	193.02
193.03	19303	UNUSED SPACE	193.03
193.04	19304	HEALTH EDUCATION	193.04

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 12:28 am
Cost Center Description			Total		
			26.00		
193.05	19305	RENTED SPACE	533,965		193.05
193.06	19306	AUGUSTA PHARMACY	37,099		193.06
200.00		Cross Foot Adjustments	911,885		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	25,032,631		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	9,617			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	123,636		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	611,210	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	0	0	2,472
1.05	00105	CAP REL COSTS-BBC	0	0	0	0	0
1.06	00106	CAP REL COSTS-BEC	0	0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,649	5,537	0
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	28,115	114,081	2,472
6.00	00600	MAINTENANCE & REPAIRS	0	1,911	19,578	70,896	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,849	1,418	0
9.00	00900	HOUSEKEEPING	0	0	4,404	1,068	0
10.00	01000	DIETARY	0	0	79	14,509	0
11.00	01100	CAFETERIA	0	0	0	6,766	0
13.00	01300	NURSING ADMINISTRATION	0	0	4,274	847	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	613	3,558	0
20.00	02000	NURSING SCHOOL	0	6,614	0	20,969	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED PRGM	0	0	0	0	0
23.01	02301	PARAMED PRGM-RADIOLOGY	0	0	0	516	0
23.02	02302	PARAMED PRGM-LABORATORY	0	0	0	516	0
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	0	0
23.04	02304	PARAMED PRGM-RESPIRATORY	0	0	0	378	0
23.05	02305	PARAMED PRGM-HIM	0	0	0	150	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	751	131,451	0
31.00	03100	INTENSIVE CARE UNIT	0	0	10,198	11,475	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	36,262	0
41.00	04100	SUBPROVIDER - IRF	0	0	4,957	5,281	0
43.00	04300	NURSERY	0	0	0	3,567	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,878	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	10,934	28,457	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,636	1,387	0
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,526	15,849	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	12,996	0
57.00	05700	CT SCAN	0	0	601	992	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,045	0
60.00	06000	LABORATORY	0	0	666	10,577	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0
65.00	06500	RESPIRATORY THERAPY	0	0	1,984	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	3,416	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0
69.00	06900	ELECTROCARDIOLOGY	0	0	8,244	4,599	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,982	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	359	0	5,928	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	544	0	8,988	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	310	3,884	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	OUTPATIENT INFUSION	0	0	0	3,496	0
91.00	09100	EMERGENCY	0	0	5,626	15,150	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,617	119,604	562,148	2,472
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,939	795	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	FASTCARE	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	522	23,588	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	571	23,679	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	36,063	436,133	6,327,898	48,417	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	3.749922	3.527557	10.353067	19.586165	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BBC (SQUARE FEET)	BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.05	1.06	2.00	4.00	5A	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-BBC	46,691				1.05
1.06	00106	CAP REL COSTS-BEC	0	26,786			1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			13,660,535		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	138,318	99,605,088	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,515	10,906	4,367,211	9,770,469	-61,793,028
6.00	00600	MAINTENANCE & REPAIRS	456	0	342,888	2,697,390	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,127	37,365	0
9.00	00900	HOUSEKEEPING	16	0	90,888	2,462,405	0
10.00	01000	DIETARY	0	0	128,579	895,281	0
11.00	01100	CAFETERIA	0	0	0	1,553,494	0
13.00	01300	NURSING ADMINISTRATION	190	4,215	854,378	7,337,789	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,508	0	77,362	0	0
20.00	02000	NURSING SCHOOL	0	5,745	105,016	4,284,314	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	759	1,110,470	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	1,425	0	285,082	0
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	2,685	69,606	0
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	292,286	0
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	104	1,895	147,949	0
23.05	02305	PARAMED ED PRGM-HIM	0	41	754	33,051	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,424,887	15,568,311	0
31.00	03100	INTENSIVE CARE UNIT	0	0	133,416	3,731,778	0
40.00	04000	SUBPROVIDER - I/PF	0	0	7,583	4,142,322	0
41.00	04100	SUBPROVIDER - I/RF	0	0	18,429	1,449,207	0
43.00	04300	NURSERY	0	0	26,699	347,299	0
44.00	04400	SKILLED NURSING FACILITY	0	0	1,006	1,547,331	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	2,510,103	9,102,899	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	34,741	1,261,765	0
53.00	05300	ANESTHESIOLOGY	0	0	166,611	210,369	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	580,269	3,496,046	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	700,798	1,182,878	0
57.00	05700	CT SCAN	0	0	131,522	542,369	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	326,231	0
60.00	06000	LABORATORY	0	0	226,293	3,053,446	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	14,870	127,961	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,125,068	0
66.00	06600	PHYSICAL THERAPY	0	0	7,863	1,384,387	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,162	743,865	0
68.00	06800	SPEECH PATHOLOGY	0	0	3,641	222,402	0
69.00	06900	ELECTROCARDIOLOGY	0	0	729,258	2,022,453	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	36,839	404,338	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71,527	297,445	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	108,460	522,815	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	354,271	4,120,117	0
74.00	07400	RENAL DIALYSIS	0	0	7,654	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	609,997	0
90.00	09000	CLINIC	0	0	0	428,327	0
90.01	04950	OUTPATIENT INFUSION	0	0	0	330,697	0
91.00	09100	EMERGENCY	0	2,301	183,557	3,728,814	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	2,049	3,466	3,156,765	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	24,871	1,106,956	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,685	26,786	13,627,656	98,271,609	-61,793,028
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,877	915,046	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	BBC (SQUARE FEET)	BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.05	1.06	2.00			
192.01 19201 FASTCARE	0	0	27,619	186,353	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 DENMAN SERVICES	0	0	287	0	0	193.01
193.02 19302 MEALS ON WHEELS	0	0	0	0	0	193.02
193.03 19303 UNUSED SPACE	636	0	0	0	0	193.03
193.04 19304 HEALTH EDUCATION	0	0	0	22,203	0	193.04
193.05 19305 RENTED SPACE	14,370	0	0	0	0	193.05
193.06 19306 AUGUSTA PHARMACY	0	0	3,096	209,877	0	193.06
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)	460,681	493,063	13,618,044	13,889,046		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	9.866591	18.407489	0.996890	0.139441		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				230,841		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.002318		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: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)		
		5.00	6.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04	
1.05	00105	CAP REL COSTS-BBC					1.05	
1.06	00106	CAP REL COSTS-BEC					1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	199,357,188				5.00	
6.00	00600	MAINTENANCE & REPAIRS	9,378,454	535,107			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,301,137	3,267	1,536,606		8.00	
9.00	00900	HOUSEKEEPING	3,769,153	5,488	15,556	110,465	9.00	
10.00	01000	DIETARY	1,823,722	14,588	11,316	3,213	236,198	10.00
11.00	01100	CAFETERIA	2,842,815	6,766	0	1,490	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,626,701	9,526	0	2,098	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,906,566	8,679	0	1,911	0	16.00
20.00	02000	NURSING SCHOOL	2,844,991	31,831	0	7,304	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,266,072	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,951,903	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	298,269	1,941	0	427	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	62,404	516	0	114	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	348,015	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	220,000	1,932	0	132	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	57,605	238	0	52	0	23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	25,707,505	132,202	514,573	29,113	142,348	30.00
31.00	03100	INTENSIVE CARE UNIT	5,263,312	21,673	86,119	4,773	17,520	31.00
40.00	04000	SUBPROVIDER - I/PF	5,311,838	36,262	19,060	7,986	40,509	40.00
41.00	04100	SUBPROVIDER - I/RF	2,007,947	10,238	83,557	2,255	15,930	41.00
43.00	04300	NURSERY	491,150	3,567	9,316	786	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,072,290	11,878	61,258	2,616	19,891	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	18,489,469	39,391	122,083	8,675	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,700,744	9,023	42,441	1,987	0	52.00
53.00	05300	ANESTHESIOLOGY	778,529	1,306	0	288	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,683,945	17,375	113,725	3,826	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,558,610	12,996	59,942	2,862	0	55.00
57.00	05700	CT SCAN	1,057,704	1,593	36,059	351	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	704,710	2,045	8,572	450	0	58.00
60.00	06000	LABORATORY	7,590,418	11,243	151	2,476	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,545,901	385	0	85	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,704,296	1,984	0	437	0	65.00
66.00	06600	PHYSICAL THERAPY	1,640,694	3,416	0	752	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	876,718	1,642	0	362	0	67.00
68.00	06800	SPEECH PATHOLOGY	271,370	556	0	122	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,893,655	12,843	61,035	2,828	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	619,628	1,982	465	436	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,843,105	6,286	8,053	1,385	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,038,613	9,533	12,212	2,099	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,298,472	4,194	0	924	0	73.00
74.00	07400	RENAL DIALYSIS	873,155	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,022,389	0	0	0	0	88.00
90.00	09000	CLINIC	572,660	0	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	467,708	3,496	505	770	0	90.01
91.00	09100	EMERGENCY	6,777,109	23,077	265,573	5,082	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	4,768,854	2,049	0	451	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,734,362	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	196,064,667	467,007	1,531,571	100,918	236,198	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,598	3,734	5,035	822	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,389,199	0	0	0	0	192.00
192.01	19201	FASTCARE	288,923	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	10,639	1,000	0	220	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
193.02	19302 MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303 UNUSED SPACE	252,324	24,746	0	0	0	193.03
193.04	19304 HEALTH EDUCATION	3,096	0	0	0	0	193.04
193.05	19305 RENTED SPACE	411,216	38,620	0	8,505	0	193.05
193.06	19306 AUGUSTA PHARMACY	918,526	0	0	0	0	193.06
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)	61,793,028	12,285,409	1,779,445	5,081,455	2,884,832	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.309961	22.958790	1.158036	46.000588	12.213617	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	7,276,644	1,505,928	82,091	276,917	475,858	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.036501	2.814256	0.053424	2.506830	2.014657	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: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)		
		11.00	13.00	16.00	20.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02	
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03	
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04	
1.05	00105	CAP REL COSTS-BBC					1.05	
1.06	00106	CAP REL COSTS-BEC					1.06	
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	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
11.00	01100	CAFETERIA	388,739				11.00	
13.00	01300	NURSING ADMINISTRATION	34,785	1,685,072			13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	179,800		16.00	
20.00	02000	NURSING SCHOOL	18,201	0	0	39,942	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	5,724	0	0	21,492	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00	
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,174	0	0	0	23.01	
23.02	02302	PARAMED ED PRGM-LABORATORY	305	0	0	0	23.02	
23.03	02303	PARAMED ED PRGM-PHARMACY	949	0	0	0	23.03	
23.04	02304	PARAMED ED PRGM-RESPIRATORY	719	0	0	0	23.04	
23.05	02305	PARAMED ED PRGM-HIM	47	0	0	0	23.05	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	87,197	603,646	107,788	30,693	14,109	30.00
31.00	03100	INTENSIVE CARE UNIT	17,924	124,082	13,266	1,983	753	31.00
40.00	04000	SUBPROVIDER - I PF	23,628	163,569	30,674	2,010	638	40.00
41.00	04100	SUBPROVIDER - I RF	7,455	51,610	12,063	1,125	884	41.00
43.00	04300	NURSERY	1,428	9,887	271	404	622	43.00
44.00	04400	SKILLED NURSING FACILITY	9,055	62,685	15,062	333	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	45,691	316,312	0	897	966	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,738	39,722	0	1,180	0	52.00
53.00	05300	ANESTHESIOLOGY	1,404	9,721	0	0	115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,041	0	0	0	213	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,719	0	0	0	0	55.00
57.00	05700	CT SCAN	2,370	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,388	0	0	0	0	58.00
60.00	06000	LABORATORY	19,584	0	0	0	164	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	841	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	11,004	0	0	36	0	65.00
66.00	06600	PHYSICAL THERAPY	5,307	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,012	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	913	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,810	0	0	0	540	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,387	0	0	0	851	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,716	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,573	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,739	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	2,036	0	0	84	0	90.00
90.01	04950	OUTPATIENT INFUSION	1,617	0	0	0	0	90.01
91.00	09100	EMERGENCY	23,151	160,269	676	1,032	1,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	100,036	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	37,695	0	165		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	388,632	1,679,234	179,800	39,942	21,492	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
		11.00	13.00	16.00	20.00	21.00	
192.01	19201 FASTCARE	0	5,838	0	0	0	192.01
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302 MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303 UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304 HEALTH EDUCATION	107	0	0	0	0	193.04
193.05	19305 RENTED SPACE	0	0	0	0	0	193.05
193.06	19306 AUGUSTA PHARMACY	0	0	0	0	0	193.06
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)	3,947,857	13,279,078	8,024,537	4,978,457	1,716,635	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.155547	7.880422	44.630350	124.642156	79.873209	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	200,192	1,373,405	405,410	683,375	52,492	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.514978	0.815042	2.254783	17.109183	2.442397	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
		22.00	23.00	23.01	23.02	23.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-BBC					1.05
1.06	00106	CAP REL COSTS-BEC					1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	21,492				22.00
23.00	02300	PARAMED PRGM		0			23.00
23.01	02301	PARAMED PRGM-RADIOLOGY			100		23.01
23.02	02302	PARAMED PRGM-LABORATORY				100	23.02
23.03	02303	PARAMED PRGM-PHARMACY					100
23.04	02304	PARAMED PRGM-RESPIRATORY					23.04
23.05	02305	PARAMED PRGM-HIM					23.05
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	14,109	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	753	0	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	638	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	884	0	0	0	41.00
43.00	04300	NURSERY	622	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	966	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	115	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213	0	100	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	164	0	0	100	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	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	540	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	851	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,637	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE		0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,492	0	100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
			22.00	23.00	23.01	23.02	23.03	
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
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)	2,556,917	0	466,849	101,935	465,524	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	118.970640	0.000000	4,668.490000	1,019.350000	4,655.240000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,246	0	50,258	12,353	13,870	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.315001	0.000000	502.580000	123.530000	138.700000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	0	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	0.000000	0.000000	0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		PARAMED PRGM-RESPIRATORY (ASSIGNED TIME)	PARAMED PRGM-HIM (TIME SPENT)		
		23.04	23.05		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100			1.00	
1.01	00101			1.01	
1.02	00102			1.02	
1.03	00103			1.03	
1.04	00104			1.04	
1.05	00105			1.05	
1.06	00106			1.06	
2.00	00200			2.00	
4.00	00400			4.00	
5.00	00500			5.00	
6.00	00600			6.00	
8.00	00800			8.00	
9.00	00900			9.00	
10.00	01000			10.00	
11.00	01100			11.00	
13.00	01300			13.00	
16.00	01600			16.00	
20.00	02000			20.00	
21.00	02100			21.00	
22.00	02200			22.00	
23.00	02300			23.00	
23.01	02301			23.01	
23.02	02302			23.02	
23.03	02303			23.03	
23.04	02304	100		23.04	
23.05	02305		179,800	23.05	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	0	107,788	30.00	
31.00	03100	0	13,266	31.00	
40.00	04000	0	30,674	40.00	
41.00	04100	0	12,063	41.00	
43.00	04300	0	271	43.00	
44.00	04400	0	15,062	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	0	0	50.00	
52.00	05200	0	0	52.00	
53.00	05300	0	0	53.00	
54.00	05400	0	0	54.00	
55.00	05500	0	0	55.00	
57.00	05700	0	0	57.00	
58.00	05800	0	0	58.00	
60.00	06000	0	0	60.00	
62.00	06200	0	0	62.00	
65.00	06500	100	0	65.00	
66.00	06600	0	0	66.00	
67.00	06700	0	0	67.00	
68.00	06800	0	0	68.00	
69.00	06900	0	0	69.00	
70.00	07000	0	0	70.00	
71.00	07100	0	0	71.00	
72.00	07200	0	0	72.00	
73.00	07300	0	0	73.00	
74.00	07400	0	0	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	88.00	
90.00	09000	0	0	90.00	
90.01	04950	0	0	90.01	
91.00	09100	0	676	91.00	
92.00	09200	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	113.00	
116.00	11600	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		100	179,800	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	190.00	
192.00	19200	0	0	192.00	
192.01	19201	0	0	192.01	
193.00	19300	0	0	193.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description			PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.04	23.05	
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	193.04
193.05	19305	RENTED SPACE	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	193.06
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)	345,921	83,793	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,459.210000	0.466034	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,227	6,064	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	222.270000	0.033726	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

		Title XVIII		Hospital		PPS	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	54,713,807		54,713,807	20,162	54,733,969	30.00
31.00	03100 INTENSIVE CARE UNIT	9,930,852		9,930,852	0	9,930,852	31.00
40.00	04000 SUBPROVIDER - I/PF	11,837,792		11,837,792	3,716	11,841,508	40.00
41.00	04100 SUBPROVIDER - I/RF	4,427,079		4,427,079	6,715	4,433,794	41.00
43.00	04300 NURSERY	927,217		927,217	0	927,217	43.00
44.00	04400 SKILLED NURSING FACILITY	4,728,231		4,728,231	483	4,728,714	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	28,733,778		28,733,778	45,383	28,779,161	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,093,993		3,093,993	0	3,093,993	52.00
53.00	05300 ANESTHESIOLOGY	1,153,939		1,153,939	0	1,153,939	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,112,377		10,112,377	0	10,112,377	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,899,044		3,899,044	0	3,899,044	55.00
57.00	05700 CT SCAN	1,504,097		1,504,097	0	1,504,097	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,014,817		1,014,817	0	1,014,817	58.00
60.00	06000 LABORATORY	10,616,171		10,616,171	0	10,616,171	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,046,360		2,046,360	0	2,046,360	62.00
65.00	06500 RESPIRATORY THERAPY	4,070,334	0	4,070,334	5,846	4,076,180	65.00
66.00	06600 PHYSICAL THERAPY	2,316,159	0	2,316,159	0	2,316,159	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,233,405	0	1,233,405	0	1,233,405	67.00
68.00	06800 SPEECH PATHOLOGY	383,133	0	383,133	0	383,133	68.00
69.00	06900 ELECTROCARDIOLOGY	5,685,637		5,685,637	2,352	5,687,989	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	902,028		902,028	3,474	905,502	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,758,944		15,758,944	0	15,758,944	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20,076,001		20,076,001	0	20,076,001	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,034,247		26,034,247	0	26,034,247	73.00
74.00	07400 RENAL DIALYSIS	1,143,799		1,143,799	0	1,143,799	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	1,339,290		1,339,290	0	1,339,290	88.00
90.00	09000 CLINIC	781,309		781,309	0	781,309	90.00
90.01	04950 OUTPATIENT INFUSION	745,370		745,370	0	745,370	90.01
91.00	09100 EMERGENCY	11,606,100		11,606,100	57,275	11,663,375	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,161,183		7,161,183	0	7,161,183	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	7,103,128		7,103,128	0	7,103,128	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	2,589,566		2,589,566		2,589,566	116.00
200.00	Subtotal (see instructions)	257,669,187	0	257,669,187	145,406	257,814,593	200.00
201.00	Less Observation Beds	7,161,183		7,161,183		7,161,183	201.00
202.00	Total (see instructions)	250,508,004	0	250,508,004	145,406	250,653,410	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

		Title XVIII			Hospital	PPS	
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	95,172,400		95,172,400		30.00
31.00	03100	INTENSIVE CARE UNIT	42,291,232		42,291,232		31.00
40.00	04000	SUBPROVIDER - IPF	28,274,069		28,274,069		40.00
41.00	04100	SUBPROVIDER - IRF	6,344,105		6,344,105		41.00
43.00	04300	NURSERY	3,664,373		3,664,373		43.00
44.00	04400	SKILLED NURSING FACILITY	6,171,335		6,171,335		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	43,350,311	105,322,792	148,673,103	0.193268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,790,789	779,487	8,570,276	0.361014	52.00
53.00	05300	ANESTHESIOLOGY	14,093,147	21,245,604	35,338,751	0.032654	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,196,903	41,935,612	58,132,515	0.173954	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,169,178	19,075,879	20,245,057	0.192592	55.00
57.00	05700	CT SCAN	29,613,139	51,881,547	81,494,686	0.018456	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,785,484	14,738,557	21,524,041	0.047148	58.00
60.00	06000	LABORATORY	60,556,345	69,020,857	129,577,202	0.081929	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,176,498	2,644,905	7,821,403	0.261636	62.00
65.00	06500	RESPIRATORY THERAPY	21,141,390	4,632,397	25,773,787	0.157925	65.00
66.00	06600	PHYSICAL THERAPY	4,431,569	476,463	4,908,032	0.471912	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,605,634	144,521	3,750,155	0.328894	67.00
68.00	06800	SPEECH PATHOLOGY	1,055,106	232,257	1,287,363	0.297611	68.00
69.00	06900	ELECTROCARDIOLOGY	45,412,514	66,016,306	111,428,820	0.051025	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	361,178	3,296,935	3,658,113	0.246583	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,402,840	52,735,105	96,137,945	0.163920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,112,115	37,715,270	72,827,385	0.275666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,053,786	64,861,360	164,915,146	0.157864	73.00
74.00	07400	RENAL DIALYSIS	2,686,887	0	2,686,887	0.425697	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	877,165	877,165		88.00
90.00	09000	CLINIC	550	755,655	756,205	1.033197	90.00
90.01	04950	OUTPATIENT INFUSION	32,566	2,479,410	2,511,976	0.296727	90.01
91.00	09100	EMERGENCY	16,275,777	33,849,200	50,124,977	0.231543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,778,480	24,124,338	27,902,818	0.256647	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	6,878,031	6,878,031		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	64,096	3,388,574	3,452,670		116.00
200.00		Subtotal (see instructions)	644,063,796	629,108,227	1,273,172,023		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	644,063,796	629,108,227	1,273,172,023		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 12:28 am
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.193573		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.361014		52.00
53.00	05300	ANESTHESIOLOGY	0.032654		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173954		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192592		55.00
57.00	05700	CT SCAN	0.018456		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047148		58.00
60.00	06000	LABORATORY	0.081929		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636		62.00
65.00	06500	RESPIRATORY THERAPY	0.158152		65.00
66.00	06600	PHYSICAL THERAPY	0.471912		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328894		67.00
68.00	06800	SPEECH PATHOLOGY	0.297611		68.00
69.00	06900	ELECTROCARDIOLOGY	0.051046		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.247533		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.275666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157864		73.00
74.00	07400	RENAL DIALYSIS	0.425697		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1.033197		90.00
90.01	04950	OUTPATIENT INFUSION	0.296727		90.01
91.00	09100	EMERGENCY	0.232686		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.256647		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

		Title XIX		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	54,713,807	54,713,807	20,162	54,733,969	30.00
31.00	03100 INTENSIVE CARE UNIT	9,930,852	9,930,852	0	9,930,852	31.00
40.00	04000 SUBPROVIDER - I/PF	11,837,792	11,837,792	3,716	11,841,508	40.00
41.00	04100 SUBPROVIDER - I/RF	4,427,079	4,427,079	6,715	4,433,794	41.00
43.00	04300 NURSERY	927,217	927,217	0	927,217	43.00
44.00	04400 SKILLED NURSING FACILITY	4,728,231	4,728,231	483	4,728,714	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	28,733,778	28,733,778	45,383	28,779,161	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,093,993	3,093,993	0	3,093,993	52.00
53.00	05300 ANESTHESIOLOGY	1,153,939	1,153,939	0	1,153,939	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,112,377	10,112,377	0	10,112,377	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,899,044	3,899,044	0	3,899,044	55.00
57.00	05700 CT SCAN	1,504,097	1,504,097	0	1,504,097	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,014,817	1,014,817	0	1,014,817	58.00
60.00	06000 LABORATORY	10,616,171	10,616,171	0	10,616,171	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,046,360	2,046,360	0	2,046,360	62.00
65.00	06500 RESPIRATORY THERAPY	4,070,334	4,070,334	5,846	4,076,180	65.00
66.00	06600 PHYSICAL THERAPY	2,316,159	2,316,159	0	2,316,159	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,233,405	1,233,405	0	1,233,405	67.00
68.00	06800 SPEECH PATHOLOGY	383,133	383,133	0	383,133	68.00
69.00	06900 ELECTROCARDIOLOGY	5,685,637	5,685,637	2,352	5,687,989	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	902,028	902,028	3,474	905,502	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,758,944	15,758,944	0	15,758,944	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20,076,001	20,076,001	0	20,076,001	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,034,247	26,034,247	0	26,034,247	73.00
74.00	07400 RENAL DIALYSIS	1,143,799	1,143,799	0	1,143,799	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	1,339,290	1,339,290	0	1,339,290	88.00
90.00	09000 CLINIC	781,309	781,309	0	781,309	90.00
90.01	04950 OUTPATIENT INFUSION	745,370	745,370	0	745,370	90.01
91.00	09100 EMERGENCY	11,606,100	11,606,100	57,275	11,663,375	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,161,183	7,161,183	0	7,161,183	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	7,103,128	7,103,128	0	7,103,128	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	2,589,566	2,589,566		2,589,566	116.00
200.00	Subtotal (see instructions)	257,669,187	257,669,187	145,406	257,814,593	200.00
201.00	Less Observation Beds	7,161,183	7,161,183		7,161,183	201.00
202.00	Total (see instructions)	250,508,004	250,508,004	145,406	250,653,410	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

		Title XIX			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	95,172,400		95,172,400		30.00
31.00	03100	INTENSIVE CARE UNIT	42,291,232		42,291,232		31.00
40.00	04000	SUBPROVIDER - IPF	28,274,069		28,274,069		40.00
41.00	04100	SUBPROVIDER - IRF	6,344,105		6,344,105		41.00
43.00	04300	NURSERY	3,664,373		3,664,373		43.00
44.00	04400	SKILLED NURSING FACILITY	6,171,335		6,171,335		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	43,350,311	105,322,792	148,673,103	0.193268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,790,789	779,487	8,570,276	0.361014	52.00
53.00	05300	ANESTHESIOLOGY	14,093,147	21,245,604	35,338,751	0.032654	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,196,903	41,935,612	58,132,515	0.173954	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,169,178	19,075,879	20,245,057	0.192592	55.00
57.00	05700	CT SCAN	29,613,139	51,881,547	81,494,686	0.018456	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,785,484	14,738,557	21,524,041	0.047148	58.00
60.00	06000	LABORATORY	60,556,345	69,020,857	129,577,202	0.081929	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,176,498	2,644,905	7,821,403	0.261636	62.00
65.00	06500	RESPIRATORY THERAPY	21,141,390	4,632,397	25,773,787	0.157925	65.00
66.00	06600	PHYSICAL THERAPY	4,431,569	476,463	4,908,032	0.471912	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,605,634	144,521	3,750,155	0.328894	67.00
68.00	06800	SPEECH PATHOLOGY	1,055,106	232,257	1,287,363	0.297611	68.00
69.00	06900	ELECTROCARDIOLOGY	45,412,514	66,016,306	111,428,820	0.051025	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	361,178	3,296,935	3,658,113	0.246583	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,402,840	52,735,105	96,137,945	0.163920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,112,115	37,715,270	72,827,385	0.275666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,053,786	64,861,360	164,915,146	0.157864	73.00
74.00	07400	RENAL DIALYSIS	2,686,887	0	2,686,887	0.425697	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	877,165	877,165	1.526839	88.00
90.00	09000	CLINIC	550	755,655	756,205	1.033197	90.00
90.01	04950	OUTPATIENT INFUSION	32,566	2,479,410	2,511,976	0.296727	90.01
91.00	09100	EMERGENCY	16,275,777	33,849,200	50,124,977	0.231543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,778,480	24,124,338	27,902,818	0.256647	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	6,878,031	6,878,031		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	64,096	3,388,574	3,452,670		116.00
200.00		Subtotal (see instructions)	644,063,796	629,108,227	1,273,172,023		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	644,063,796	629,108,227	1,273,172,023		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 12:28 am
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	OUTPATIENT INFUSION	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part I Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	5,369,876	0	5,369,876	49,673	108.10	30.00
31.00	INTENSIVE CARE UNIT	758,429		758,429	5,344	141.92	31.00
40.00	SUBPROVIDER - IPF	1,005,819	0	1,005,819	12,380	81.25	40.00
41.00	SUBPROVIDER - IRF	313,513	0	313,513	4,885	64.18	41.00
43.00	NURSERY	104,187		104,187	2,413	43.18	43.00
44.00	SKILLED NURSING FACILITY	381,169		381,169	6,109	62.39	44.00
200.00	Total (lines 30 through 199)	7,932,993		7,932,993	80,804		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	25,239	2,728,336				
31.00	INTENSIVE CARE UNIT	2,757	391,273				
40.00	SUBPROVIDER - IPF	1,630	132,438				
41.00	SUBPROVIDER - IRF	3,329	213,655				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,585	286,058				
200.00	Total (lines 30 through 199)	37,540	3,751,760				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,990,098	148,673,103	0.033564	24,674,768	828,184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,904	8,570,276	0.024375	50,457	1,230	52.00
53.00	05300	ANESTHESIOLOGY	235,479	35,338,751	0.006663	6,632,530	44,193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,504,413	58,132,515	0.025879	9,175,734	237,459	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	978,682	20,245,057	0.048342	823,796	39,824	55.00
57.00	05700	CT SCAN	191,876	81,494,686	0.002354	15,303,508	36,024	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,707	21,524,041	0.002588	3,471,417	8,984	58.00
60.00	06000	LABORATORY	830,418	129,577,202	0.006409	31,642,850	202,799	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,263	7,821,403	0.009878	2,601,424	25,697	62.00
65.00	06500	RESPIRATORY THERAPY	221,779	25,773,787	0.008605	11,637,090	100,137	65.00
66.00	06600	PHYSICAL THERAPY	120,532	4,908,032	0.024558	1,264,802	31,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,953	3,750,155	0.016520	759,954	12,554	67.00
68.00	06800	SPEECH PATHOLOGY	22,148	1,287,363	0.017204	382,791	6,586	68.00
69.00	06900	ELECTROCARDIOLOGY	1,001,525	111,428,820	0.008988	23,709,463	213,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	143,406	3,658,113	0.039202	208,886	8,189	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	693,080	96,137,945	0.007209	22,384,944	161,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	944,772	72,827,385	0.012973	19,168,174	248,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,147	164,915,146	0.006853	49,443,594	338,837	73.00
74.00	07400	RENAL DIALYSIS	39,501	2,686,887	0.014701	1,103,371	16,221	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	71,029	877,165	0.080976	0	0	88.00
90.00	09000	CLINIC	91,191	756,205	0.120590	550	66	90.00
90.01	04950	OUTPATIENT INFUSION	66,662	2,511,976	0.026538	26,753	710	90.01
91.00	09100	EMERGENCY	893,996	50,124,977	0.017835	7,584,058	135,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,577	27,902,818	0.025179	1,807,612	45,514	92.00
200.00		Total (lines 50 through 199)	15,277,138	1,080,923,808		233,858,526	2,742,674	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,825,642	0	50,234	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	247,165	0	6,182	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	250,531	0	14,295	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	140,222	0	5,622	0	41.00
43.00	04300	NURSERY	0	50,355	0	126	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	41,506	0	7,019	0	44.00
200.00		Total (lines 30 through 199)	0	4,555,421	0	83,478	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,875,876	49,673	78.03	25,239	30.00
31.00	03100	INTENSIVE CARE UNIT		253,347	5,344	47.41	2,757	31.00
40.00	04000	SUBPROVIDER - IPF	0	264,826	12,380	21.39	1,630	40.00
41.00	04100	SUBPROVIDER - IRF	0	145,844	4,885	29.86	3,329	41.00
43.00	04300	NURSERY		50,481	2,413	20.92	0	43.00
44.00	04400	SKILLED NURSING FACILITY		48,525	6,109	7.94	4,585	44.00
200.00		Total (lines 30 through 199)		4,638,899	80,804		37,540	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
			9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,969,399	0				30.00
31.00	03100	INTENSIVE CARE UNIT	130,709	0				31.00
40.00	04000	SUBPROVIDER - IPF	34,866	0				40.00
41.00	04100	SUBPROVIDER - IRF	99,404	0				41.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	36,405	0				44.00
200.00		Total (lines 30 through 199)	2,270,783	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description	Title XVIII			Hospital		PPS	
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	111,804	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	147,078	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	466,849	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	101,935	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	4,487	0	345,921	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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	465,524	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	10,470	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	128,631	0	315	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	500,531	0	6,574	92.00
200.00	Total (lines 50 through 199)	0	0	903,001	0	1,387,118	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	111,804	111,804	148,673,103	0.000752	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,078	147,078	8,570,276	0.017161	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35,338,751	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	466,849	466,849	58,132,515	0.008031	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,245,057	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	81,494,686	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,524,041	0.000000	58.00
60.00	06000	LABORATORY	0	101,935	101,935	129,577,202	0.000787	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,821,403	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	350,408	350,408	25,773,787	0.013596	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,908,032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,750,155	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,287,363	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	111,428,820	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,658,113	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	96,137,945	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,827,385	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	465,524	465,524	164,915,146	0.002823	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,686,887	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	877,165	0.000000	88.00
90.00	09000	CLINIC	0	10,470	10,470	756,205	0.013845	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	2,511,976	0.000000	90.01
91.00	09100	EMERGENCY	0	128,946	128,946	50,124,977	0.002572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	507,105	507,105	27,902,818	0.018174	92.00
200.00		Total (lines 50 through 199)	0	2,290,119	2,290,119	1,080,923,808		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		Title XVIII					
		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	0.000752	24,674,768	18,555	40,469,331	30,433	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.017161	50,457	866	17,687	304	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	6,632,530	0	6,783,726	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.008031	9,175,734	73,690	11,891,254	95,499	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	823,796	0	12,875,773	0	55.00
57.00	05700 CT SCAN	0.000000	15,303,508	0	14,917,533	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,471,417	0	4,750,698	0	58.00
60.00	06000 LABORATORY	0.000787	31,642,850	24,903	9,962,606	7,841	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,601,424	0	1,061,417	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.013596	11,637,090	158,218	2,374,550	32,284	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,264,802	0	100,021	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	759,954	0	61,442	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	382,791	0	4,492	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	23,709,463	0	29,152,374	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	208,886	0	1,086,093	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,384,944	0	20,196,418	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	19,168,174	0	17,784,411	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.002823	49,443,594	139,579	21,498,438	60,690	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,103,371	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.013845	550	8	360,944	4,997	90.00
90.01	04950 OUTPATIENT INFUSION	0.000000	26,753	0	1,226,968	0	90.01
91.00	09100 EMERGENCY	0.002572	7,584,058	19,506	7,271,073	18,701	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.018174	1,807,612	32,852	8,920,732	162,125	92.00
200.00	Total (lines 50 through 199)		233,858,526	468,177	212,767,981	412,874	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
Title XVIII				
		Hospital		PPS
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.193268	40,469,331	0	0	7,821,427	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	17,687	0	0	6,385	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	6,783,726	0	0	221,516	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	11,891,254	0	0	2,068,531	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	12,875,773	0	0	2,479,771	55.00
57.00	05700 CT SCAN	0.018456	14,917,533	0	0	275,318	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	4,750,698	0	0	223,986	58.00
60.00	06000 LABORATORY	0.081929	9,962,606	0	0	816,226	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	1,061,417	0	0	277,705	62.00
65.00	06500 RESPIRATORY THERAPY	0.157925	2,374,550	0	0	375,001	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	100,021	0	0	47,201	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	61,442	0	0	20,208	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	4,492	0	0	1,337	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051025	29,152,374	0	0	1,487,500	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246583	1,086,093	0	0	267,812	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	20,196,418	0	0	3,310,597	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	17,784,411	0	0	4,902,557	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	21,498,438	0	0	3,393,829	73.00
74.00	07400 RENAL DIALYSIS	0.425697	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000 CLINIC	1.033197	360,944	0	0	372,926	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	1,226,968	0	0	364,075	90.01
91.00	09100 EMERGENCY	0.231543	7,271,073	0	0	1,683,566	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	8,920,732	0	0	2,289,479	92.00
200.00	Subtotal (see instructions)		212,767,981	0	0	32,706,953	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		212,767,981	0	0	32,706,953	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
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	0	201.00
202.00	Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,990,098	148,673,103	0.033564	3,911	131	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	208,904	8,570,276	0.024375	0	0	52.00
53.00	05300 ANESTHESIOLOGY	235,479	35,338,751	0.006663	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,504,413	58,132,515	0.025879	22,948	594	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	978,682	20,245,057	0.048342	0	0	55.00
57.00	05700 CT SCAN	191,876	81,494,686	0.002354	66,404	156	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	55,707	21,524,041	0.002588	44,293	115	58.00
60.00	06000 LABORATORY	830,418	129,577,202	0.006409	373,955	2,397	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	77,263	7,821,403	0.009878	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	221,779	25,773,787	0.008605	9,450	81	65.00
66.00	06600 PHYSICAL THERAPY	120,532	4,908,032	0.024558	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	61,953	3,750,155	0.016520	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	22,148	1,287,363	0.017204	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,001,525	111,428,820	0.008988	82,115	738	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	143,406	3,658,113	0.039202	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	693,080	96,137,945	0.007209	783	6	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	944,772	72,827,385	0.012973	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,130,147	164,915,146	0.006853	545,626	3,739	73.00
74.00	07400 RENAL DIALYSIS	39,501	2,686,887	0.014701	17,667	260	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	71,029	877,165	0.080976	0	0	88.00
90.00	09000 CLINIC	91,191	756,205	0.120590	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	66,662	2,511,976	0.026538	0	0	90.01
91.00	09100 EMERGENCY	893,996	50,124,977	0.017835	192,890	3,440	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	27,902,818	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	14,574,561	1,080,923,808		1,360,042	11,657	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	111,804	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	147,078	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	466,849	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	101,935	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	4,487	0	345,921	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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	465,524	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	10,470	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	128,631	0	315	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	402,470	0	1,380,544	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	111,804	111,804	148,673,103	0.000752	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	147,078	147,078	8,570,276	0.017161	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	35,338,751	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	466,849	466,849	58,132,515	0.008031	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,245,057	0.000000	55.00
57.00	05700 CT SCAN	0	0	0	81,494,686	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,524,041	0.000000	58.00
60.00	06000 LABORATORY	0	101,935	101,935	129,577,202	0.000787	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,821,403	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	0	350,408	350,408	25,773,787	0.013596	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	4,908,032	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	3,750,155	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,287,363	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	111,428,820	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,658,113	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	96,137,945	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,827,385	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	465,524	465,524	164,915,146	0.002823	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	2,686,887	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	877,165	0.000000	88.00
90.00	09000 CLINIC	0	10,470	10,470	756,205	0.013845	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	2,511,976	0.000000	90.01
91.00	09100 EMERGENCY	0	128,946	128,946	50,124,977	0.002572	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	27,902,818	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,783,014	1,783,014	1,080,923,808		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000752	3,911	3	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.017161	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.008031	22,948	184	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	66,404	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	44,293	0	0	0	58.00
60.00	06000 LABORATORY	0.000787	373,955	294	1,678	1	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.013596	9,450	128	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	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	0.000000	82,115	0	327	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	783	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.002823	545,626	1,540	510	1	73.00
74.00	07400 RENAL DIALYSIS	0.000000	17,667	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.013845	0	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.002572	192,890	496	1,166	3	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,360,042	2,645	3,681	5	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.193268	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	0	0	0	55.00
57.00	05700 CT SCAN	0.018456	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	0	0	0	58.00
60.00	06000 LABORATORY	0.081929	1,678	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.157925	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051025	327	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246583	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	510	0	1,899	73.00
74.00	07400 RENAL DIALYSIS	0.425697	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	1.033197	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	0	0	0	90.01
91.00	09100 EMERGENCY	0.231543	1,166	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	0	0	92.00
200.00	Subtotal (see instructions)		3,681	0	1,899	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		3,681	0	1,899	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	300	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
90.00 09000 CLINIC	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	300	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	300	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part II Date/Time Prepared: 2/27/2019 12:28 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,990,098	148,673,103	0.033564	52,109	1,749	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,904	8,570,276	0.024375	0	0	52.00
53.00	05300	ANESTHESIOLOGY	235,479	35,338,751	0.006663	9,135	61	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,504,413	58,132,515	0.025879	198,132	5,127	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	978,682	20,245,057	0.048342	0	0	55.00
57.00	05700	CT SCAN	191,876	81,494,686	0.002354	93,055	219	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,707	21,524,041	0.002588	56,066	145	58.00
60.00	06000	LABORATORY	830,418	129,577,202	0.006409	821,057	5,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,263	7,821,403	0.009878	32,555	322	62.00
65.00	06500	RESPIRATORY THERAPY	221,779	25,773,787	0.008605	287,674	2,475	65.00
66.00	06600	PHYSICAL THERAPY	120,532	4,908,032	0.024558	1,084,413	26,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,953	3,750,155	0.016520	1,060,795	17,524	67.00
68.00	06800	SPEECH PATHOLOGY	22,148	1,287,363	0.017204	284,062	4,887	68.00
69.00	06900	ELECTROCARDIOLOGY	1,001,525	111,428,820	0.008988	57,525	517	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	143,406	3,658,113	0.039202	4,743	186	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	693,080	96,137,945	0.007209	106,470	768	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	944,772	72,827,385	0.012973	33,118	430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,147	164,915,146	0.006853	1,100,135	7,539	73.00
74.00	07400	RENAL DIALYSIS	39,501	2,686,887	0.014701	109,313	1,607	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	71,029	877,165	0.080976	0	0	88.00
90.00	09000	CLINIC	91,191	756,205	0.120590	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	66,662	2,511,976	0.026538	0	0	90.01
91.00	09100	EMERGENCY	893,996	50,124,977	0.017835	1,166	21	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,902,818	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	14,574,561	1,080,923,808		5,391,523	75,470	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	111,804	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	147,078	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	466,849	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	101,935	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	4,487	0	345,921	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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	465,524	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	10,470	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	128,631	0	315	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	402,470	0	1,380,544	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	111,804	111,804	148,673,103	0.000752	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	147,078	147,078	8,570,276	0.017161	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	35,338,751	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	466,849	466,849	58,132,515	0.008031	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,245,057	0.000000	55.00
57.00	05700 CT SCAN	0	0	0	81,494,686	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,524,041	0.000000	58.00
60.00	06000 LABORATORY	0	101,935	101,935	129,577,202	0.000787	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,821,403	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	0	350,408	350,408	25,773,787	0.013596	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	4,908,032	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	3,750,155	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,287,363	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	111,428,820	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,658,113	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	96,137,945	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,827,385	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	465,524	465,524	164,915,146	0.002823	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	2,686,887	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	877,165	0.000000	88.00
90.00	09000 CLINIC	0	10,470	10,470	756,205	0.013845	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	2,511,976	0.000000	90.01
91.00	09100 EMERGENCY	0	128,946	128,946	50,124,977	0.002572	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	27,902,818	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,783,014	1,783,014	1,080,923,808		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Title XVIII		Subprovider - IRF	PPS
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.000752	52,109	39	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.017161	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	9,135	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.008031	198,132	1,591	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00 05700 CT SCAN	0.000000	93,055	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	56,066	0	0	0	58.00
60.00 06000 LABORATORY	0.000787	821,057	646	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	32,555	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.013596	287,674	3,911	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	1,084,413	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1,060,795	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	284,062	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	57,525	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	4,743	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	106,470	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	33,118	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.002823	1,100,135	3,106	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	109,313	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00 09000 CLINIC	0.013845	0	0	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.002572	1,166	3	215	1	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		5,391,523	9,296	215	1	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.193268	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	0	0	0	55.00
57.00	05700 CT SCAN	0.018456	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	0	0	0	58.00
60.00	06000 LABORATORY	0.081929	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.157925	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051025	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246583	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	0	0	2,292	73.00
74.00	07400 RENAL DIALYSIS	0.425697	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	1.033197	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	0	0	0	90.01
91.00	09100 EMERGENCY	0.231543	215	0	0	50 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	0	0	0 92.00
200.00	Subtotal (see instructions)		215	0	2,292	50 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		215	0	2,292	50 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	362	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
90.00 09000 CLINIC	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
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	362	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	362	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	111,804	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	147,078	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	466,849	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	101,935	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	4,487	0	345,921	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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	465,524	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	10,470	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	128,631	0	315	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	402,470	0	1,380,544	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Title XVIII		Skilled Nursing Facility	PPS
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	111,804	111,804	148,673,103	0.000752	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	147,078	147,078	8,570,276	0.017161	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	35,338,751	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	466,849	466,849	58,132,515	0.008031	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	20,245,057	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	81,494,686	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,524,041	0.000000	58.00
60.00 06000 LABORATORY	0	101,935	101,935	129,577,202	0.000787	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,821,403	0.000000	62.00
65.00 06500 RESPIRATORY THERAPY	0	350,408	350,408	25,773,787	0.013596	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	4,908,032	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,750,155	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,287,363	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	111,428,820	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,658,113	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	96,137,945	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,827,385	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	465,524	465,524	164,915,146	0.002823	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	2,686,887	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	877,165	0.000000	88.00
90.00 09000 CLINIC	0	10,470	10,470	756,205	0.013845	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	0	2,511,976	0.000000	90.01
91.00 09100 EMERGENCY	0	128,946	128,946	50,124,977	0.002572	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	27,902,818	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1,783,014	1,783,014	1,080,923,808		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
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Title XVIII		Skilled Nursing Facility	PPS
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000752	16,721	13	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.017161	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	578	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.008031	215,068	1,727	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	2,311	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000787	1,236,853	973	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	99,262	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.013596	1,039,519	14,133	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	719,212	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	681,577	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	46,479	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	72,143	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	3,795	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	223,788	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	783	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.002823	2,549,901	7,198	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	28,708	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.013845	0	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.000000	347	0	0	0	90.01
91.00	09100 EMERGENCY	0.002572	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		6,937,045	24,044	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.193268	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	0	0	0	55.00
57.00	05700 CT SCAN	0.018456	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	0	0	0	58.00
60.00	06000 LABORATORY	0.081929	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.157925	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051025	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246583	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	0	0	58,663	73.00
74.00	07400 RENAL DIALYSIS	0.425697	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	1.033197	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	0	0	0	90.01
91.00	09100 EMERGENCY	0.231543	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	58,663	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	58,663	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 12:28 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,261	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
90.00 09000 CLINIC	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	9,261	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	9,261	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		49,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		49,673	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)		43,174	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		25,239	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		54,733,969	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		54,733,969	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		54,733,969	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,101.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		27,810,602	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)		27,810,602	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,930,852	5,344	1,858.32	2,757	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)				34,013,880	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				66,947,870	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)				5,219,717	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				3,210,851	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				8,430,568	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				58,517,302	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				6,499	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,101.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				7,161,183	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,369,876	54,733,969	0.098109	7,161,183	702,577	90.00
91.00	Nursing School cost	3,825,642	54,733,969	0.069895	7,161,183	500,531	91.00
92.00	Allied health cost	50,234	54,733,969	0.000918	7,161,183	6,574	92.00
93.00	All other Medical Education	0	54,733,969	0.000000	7,161,183	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,380 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,380 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)			12,380 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,630 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			11,841,508 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			11,841,508 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			11,841,508 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			956.50 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,559,095 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)			1,559,095 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	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
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					183,055	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,742,150	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					167,304	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,302	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					181,606	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,560,544	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,005,819	11,841,508	0.084940	0	0	90.00
91.00	Nursing School cost	250,531	11,841,508	0.021157	0	0	91.00
92.00	Allied health cost	14,295	11,841,508	0.001207	0	0	92.00
93.00	All other Medical Education	0	11,841,508	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,885	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)		4,885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,329	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,433,794	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,433,794	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		4,433,794	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		907.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,021,500	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,021,500	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	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
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,366,840	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,388,340	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					313,059	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					84,766	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					397,825	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,990,515	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	313,513	4,433,794	0.070710	0	0	90.00
91.00	Nursing School cost	140,222	4,433,794	0.031626	0	0	91.00
92.00	Allied health cost	5,622	4,433,794	0.001268	0	0	92.00
93.00	All other Medical Education	0	4,433,794	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,109	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,109	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)		6,109	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,585	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,728,714	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,728,714	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		4,728,714	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
				Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					4,728,714	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					774.06	71.00
72.00	Program routine service cost (line 9 x line 71)					3,549,065	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					3,549,065	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					3,549,065	83.00
84.00	Program inpatient ancillary services (see instructions)					1,366,206	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					4,915,271	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 12:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		59,478,079		30.00
31.00	03100 INTENSIVE CARE UNIT		21,126,868		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.193573	24,674,768	4,776,369	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	50,457	18,216	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	6,632,530	216,579	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	9,175,734	1,596,156	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	823,796	158,657	55.00
57.00	05700 CT SCAN	0.018456	15,303,508	282,442	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	3,471,417	163,670	58.00
60.00	06000 LABORATORY	0.081929	31,642,850	2,592,467	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	2,601,424	680,626	62.00
65.00	06500 RESPIRATORY THERAPY	0.158152	11,637,090	1,840,429	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	1,264,802	596,875	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	759,954	249,944	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	382,791	113,923	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051046	23,709,463	1,210,273	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.247533	208,886	51,706	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	22,384,944	3,669,340	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	19,168,174	5,284,014	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	49,443,594	7,805,364	73.00
74.00	07400 RENAL DIALYSIS	0.425697	1,103,371	469,702	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.033197	550	568	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	26,753	7,938	90.01
91.00	09100 EMERGENCY	0.232686	7,584,058	1,764,704	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	1,807,612	463,918	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		233,858,526	34,013,880	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)		233,858,526		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		3,745,407	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.193573	3,911	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.361014	0	52.00
53.00	05300	ANESTHESIOLOGY	0.032654	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173954	22,948	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192592	0	55.00
57.00	05700	CT SCAN	0.018456	66,404	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047148	44,293	58.00
60.00	06000	LABORATORY	0.081929	373,955	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.158152	9,450	65.00
66.00	06600	PHYSICAL THERAPY	0.471912	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328894	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.297611	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051046	82,115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.247533	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.275666	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.157864	545,626	73.00
74.00	07400	RENAL DIALYSIS	0.425697	17,667	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	1.033197	0	90.00
90.01	04950	OUTPATIENT INFUSION	0.296727	0	90.01
91.00	09100	EMERGENCY	0.232686	192,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,360,042	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)		1,360,042	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		4,368,607	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.193573	52,109	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032654	9,135	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	198,132	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	0	55.00
57.00	05700 CT SCAN	0.018456	93,055	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	56,066	58.00
60.00	06000 LABORATORY	0.081929	821,057	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	32,555	62.00
65.00	06500 RESPIRATORY THERAPY	0.158152	287,674	65.00
66.00	06600 PHYSICAL THERAPY	0.471912	1,084,413	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	1,060,795	67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	284,062	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051046	57,525	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.247533	4,743	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	106,470	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	33,118	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	1,100,135	73.00
74.00	07400 RENAL DIALYSIS	0.425697	109,313	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	1.033197	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	0	90.01
91.00	09100 EMERGENCY	0.232686	1,166	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,391,523	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)		5,391,523	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - I/PF		0	40.00
41.00	04100 SUBPROVIDER - I/RF		0	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.193573	16,721	3,237 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.361014	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.032654	578	19 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.173954	215,068	37,412 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.192592	0	0 55.00
57.00	05700 CT SCAN	0.018456	2,311	43 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.047148	0	0 58.00
60.00	06000 LABORATORY	0.081929	1,236,853	101,334 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261636	99,262	25,971 62.00
65.00	06500 RESPIRATORY THERAPY	0.158152	1,039,519	164,402 65.00
66.00	06600 PHYSICAL THERAPY	0.471912	719,212	339,405 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328894	681,577	224,167 67.00
68.00	06800 SPEECH PATHOLOGY	0.297611	46,479	13,833 68.00
69.00	06900 ELECTROCARDIOLOGY	0.051046	72,143	3,683 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.247533	3,795	939 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.163920	223,788	36,683 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.275666	783	216 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.157864	2,549,901	402,538 73.00
74.00	07400 RENAL DIALYSIS	0.425697	28,708	12,221 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000 CLINIC	1.033197	0	0 90.00
90.01	04950 OUTPATIENT INFUSION	0.296727	347	103 90.01
91.00	09100 EMERGENCY	0.232686	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.256647	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,937,045	1,366,206 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		6,937,045	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		52,589,790	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,416,782	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		6,917,669	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		228.50	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		13.16	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		17.92	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		13.16	12.00
13.00	Total allowable FTE count for the prior year.		17.01	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		17.42	14.00
15.00	Sum of lines 12 through 14 divided by 3.		15.86	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		15.86	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.069409	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.075298	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.069409	21.00
22.00	IME payment adjustment (see instructions)		1,956,025	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		257,296	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		4.76	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		1,956,025	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		257,296	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.27	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.08	31.00
32.00	Sum of lines 30 and 31		23.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.48	33.00
34.00	Disproportionate share adjustment (see instructions)		1,114,904	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000646329	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	4,373,511	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	4,373,511	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4,373,511		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		61,451,012		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		66,211,103		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			66,468,399	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			4,595,181	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			578,961	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			2,100,108	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			468,177	58.00
59.00	Total (sum of amounts on lines 49 through 58)			74,210,826	59.00
60.00	Primary payer payments			24,897	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			74,185,929	61.00
62.00	Deductibles billed to program beneficiaries			5,700,612	62.00
63.00	Coinurance billed to program beneficiaries			104,123	63.00
64.00	Allowable bad debts (see instructions)			1,307,884	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			850,125	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,123,185	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			69,231,319	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			23,281	70.93
70.94	HRR adjustment amount (see instructions)			-368,131	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0 70.97
70.98	Low Volume Payment-3			0 70.98
70.99	HAC adjustment amount (see instructions)			0 70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		68,886,469	71.00
71.01	Sequestration adjustment (see instructions)		1,377,729	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		66,843,381	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		665,359	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,750,000	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0 95.00
96.00	Time value of money for capital related expenses (see instructions)			0 96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)			0 100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0 102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0 104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
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
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet DSH	
		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.27	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	19.08	0.00			19.08	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	23.35	0.00			19.08	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	228.50	0.00			228.50	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.48	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2.22	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	5,675	0			5,675	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	1,192	0			1,192	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3,079	0			3,079	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	9,946	0			9,946	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	50,931	0			50,931	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	425	0			425	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	766	0			766	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	52,122	0			52,122	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	19.08	0.00			19.08	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0015		Period: From 10/01/2017 To 09/30/2018		Worksheet DSH Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.48		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		8.48		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.48		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet DSH Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.15		29.00
30.00	Line 28 or 29 as applicable	5.15		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		32,294,079	2.00
3.00	OPPS payments		32,475,437	3.00
4.00	Outlier payment (see instructions)		181,730	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.897	5.00
6.00	Line 2 times line 5		28,967,789	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		412,874	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		33,070,041	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,014,023	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)		27,056,018	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		243,047	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)		27,299,065	30.00
31.00	Primary payer payments		3,885	31.00
32.00	Subtotal (line 30 minus line 31)		27,295,180	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		731,695	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		475,602	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		605,570	36.00
37.00	Subtotal (see instructions)		27,770,782	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1,022	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		27,769,760	40.00
40.01	Sequestration adjustment (see instructions)		555,395	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		27,204,044	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		10,321	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital
			PPS Overrides
WORKSHEET OVERRIDE VALUES			1.00
112.00	Override of Ancillary service charges (line 12)		0   112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		300	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		500	2.00
3.00	OPPS payments		939	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		5	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		300	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		1,899	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)		1,899	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,899	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,599	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		300	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		944	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		105	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)		1,139	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)		1,139	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,139	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,139	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 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)		1,139	40.00
40.01	Sequestration adjustment (see instructions)		23	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,246	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-130	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
	Title XVIII	Subprovider - IPF	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		362	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		49	2.00
3.00	OPPS payments		191	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		1	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		362	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		2,292	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)		2,292	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,292	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,930	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)		362	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)		192	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		554	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)		554	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		554	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		554	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 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)		554	40.00
40.01	Sequestration adjustment (see instructions)		11	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		663	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-120	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
	Title XVIII	Subprovider - IRF	PPS
			Overrides 1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		9,261	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,261	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		58,663	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)		58,663	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		58,663	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		49,402	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		9,261	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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		9,261	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)		9,261	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		9,261	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		9,261	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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 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)		9,261	40.00
40.01	Sequestration adjustment (see instructions)		185	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		57,490	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-48,414	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 12:28 am
	Title XVIII	Skilled Nursing Facility	PPS
			Overrides 1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		68,260,731		27,204,044	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/26/2018	675,647		0	3.50	
3.51		09/10/2018	741,703		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)		-1,417,350		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)		66,843,381		27,204,044	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		665,359		10,321	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		67,508,740		27,214,365	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: 14-0015  
Component CCN: 14-S015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,158,290		1,246	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,158,290		1,246	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		135,591		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		130	6.02
7.00	Total Medicare program liability (see instructions)		1,293,881		1,116	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: 14-0015  
Component CCN: 14-T015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Title XVIII

Subprovider -  
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		5,229,331		663	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,229,331		663	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		110,581		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		120	6.02
7.00	Total Medicare program liability (see instructions)		5,339,912		543	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: 14-0015  
Component CCN: 14-5643

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Title XVIII

Skilled Nursing  
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,537,695		57,490	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,537,695		57,490	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		60,763		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		48,414	6.02
7.00	Total Medicare program liability (see instructions)		1,598,458		9,076	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: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,454,524 1.00
2.00	Net IPF PPS Outlier Payments			1,808 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			33.917808 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,456,332 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,456,332 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,456,332 18.00
19.00	Deductibles			186,736 19.00
20.00	Subtotal (line 18 minus line 19)			1,269,596 20.00
21.00	Coinsurance			87,662 21.00
22.00	Subtotal (line 20 minus line 21)			1,181,934 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			155,142 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			100,842 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			146,098 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,282,776 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			37,511 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,320,287 31.00
31.01	Sequestration adjustment (see instructions)			26,406 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,158,290 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			135,591 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			1,808 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part III Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			5,151,982 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0222 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			127,769 3.00
4.00	Outlier Payments			106,549 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			13.383562 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			5,386,300 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,386,300 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,386,300 19.00
20.00	Deductibles			20,028 20.00
21.00	Subtotal (line 19 minus line 20)			5,366,272 21.00
22.00	Coinsurance			26,082 22.00
23.00	Subtotal (line 21 minus line 22)			5,340,190 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,340,190 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			108,700 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,448,890 32.00
32.01	Sequestration adjustment (see instructions)			108,978 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			5,229,331 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			110,581 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			106,549 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,684,007	1.00
2.00	Routine service other pass through costs		36,405	2.00
3.00	Ancillary service other pass through costs		24,044	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,744,456	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		114,930	7.00
8.00	Allowable bad debts (see instructions)		2,391	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		137	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		1,554	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,631,080	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,631,080	15.00
15.01	Sequestration adjustment (see instructions)		32,622	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,537,695	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		60,763	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E-4 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			18.00	6.00
7.00	Enter the lesser of line 5 or line 6			18.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	18.00	0.00	18.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	18.00	0.00	18.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	18.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.25	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.01	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.42	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	17.42	0.00		17.00
18.00	Per resident amount	85,514.60	0.00		18.00
19.00	Approved amount for resident costs	1,489,664	0	1,489,664	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,489,664	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	32,955	4,168		26.00
27.00	Total Inpatient Days (see instructions)	66,208	66,208		27.00
28.00	Ratio of inpatient days to total inpatient days	0.497750	0.062953		28.00
29.00	Program direct GME amount	741,480	93,779		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		13,251		30.00
31.00	Net Program direct GME amount			822,008	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet E-4 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,686,887	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		78,371,881	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		24,897	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		78,346,984	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		32,893,897	42.00
43.00	Primary payer payments (see instructions)		3,885	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		32,890,012	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		111,236,996	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.704325	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.295675	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		822,008	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		578,961	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		243,047	50.00

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

Provider CCN: 14-0015

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

Worksheet G

Date/Time Prepared:  
2/27/2019 12:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	92,763,691	0	0	0	1.00
2.00	Temporary investments	158,532,709	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	215,090,518	0	0	0	4.00
5.00	Other receivable	11,597,832	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-159,782,953	0	0	0	6.00
7.00	Inventory	7,189,485	0	0	0	7.00
8.00	Prepaid expenses	6,858,846	0	0	0	8.00
9.00	Other current assets	200,282	0	0	0	9.00
10.00	Due from other funds	1,128,331	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	333,578,741	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	14,452,937	0	0	0	12.00
13.00	Land improvements	8,032,867	0	0	0	13.00
14.00	Accumulated depreciation	-4,750,048	0	0	0	14.00
15.00	Buildings	225,646,016	0	0	0	15.00
16.00	Accumulated depreciation	-87,151,408	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	170,213,387	0	0	0	23.00
24.00	Accumulated depreciation	-106,708,674	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	219,735,077	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	20,381,388	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	283,901	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,665,289	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	573,979,107	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	17,588,948	0	0	0	37.00
38.00	Salaries, wages, and fees payable	19,577,713	0	0	0	38.00
39.00	Payroll taxes payable	1,504,688	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,615,984	0	0	0	40.00
41.00	Deferred income	2,511,960	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	22,369,280	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	69,168,573	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	76,062,602	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	61,016,058	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	137,078,660	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	206,247,233	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	367,731,874				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)	367,731,874	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	573,979,107	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0015

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

Worksheet G-1

Date/Time Prepared:  
2/27/2019 12:28 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		304,259,523		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		50,545,775			2.00
3.00	Total (sum of line 1 and line 2)		354,805,298		0	3.00
4.00	PENSION LIABILITY ADJUSTMENT	12,639,577		0		4.00
5.00	CHANGE IN TEMP RESTRICTED	287,000		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		12,926,577		0	10.00
11.00	Subtotal (line 3 plus line 10)		367,731,875		0	11.00
12.00	ROUNDING	1		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		367,731,874		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	PENSION LIABILITY ADJUSTMENT		0			4.00
5.00	CHANGE IN TEMP RESTRICTED		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	ROUNDING		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: 14-0015

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	103,821,843		103,821,843	1.00
2.00	SUBPROVIDER - IPF	28,559,943		28,559,943	2.00
3.00	SUBPROVIDER - IRF	6,379,325		6,379,325	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	6,191,559		6,191,559	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)	144,952,670		144,952,670	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	42,706,548		42,706,548	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)	42,706,548		42,706,548	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	187,659,218		187,659,218	17.00
18.00	Ancillary services	493,331,517	695,526,457	1,188,857,974	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	877,165	877,165	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		6,878,031	6,878,031	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	64,096	3,388,574	3,452,670	26.00
27.00	NURSERY	3,920,751	0	3,920,751	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	684,975,582	706,670,227	1,391,645,809	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		390,359,272		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)		390,359,272		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0015

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

Worksheet G-3

Date/Time Prepared:  
2/27/2019 12:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,391,645,809	1.00
2.00	Less contractual allowances and discounts on patients' accounts	983,370,672	2.00
3.00	Net patient revenues (line 1 minus line 2)	408,275,137	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	390,359,272	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,915,865	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	10,755,697	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	1,606,650	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	115,919	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,681,272	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	787,943	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	11,951,453	24.00
24.01	TRANSFERS	1,547,242	24.01
24.02	TRANSFERS	1,183,734	24.02
25.00	Total other income (sum of lines 6-24)	32,629,910	25.00
26.00	Total (line 5 plus line 25)	50,545,775	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)	50,545,775	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet H

HHA CCN: 14-7031

To 09/30/2018

Date/Time Prepared: 2/27/2019 12:28 am

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	628,511	0	0	0	0	628,511	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	1,159,308	0	160,147	0	441,538	1,760,993	6.00
7.00	Physical Therapy	823,045	0	81,999	0	226,075	1,131,119	7.00
8.00	Occupational Therapy	240,019	0	23,707	0	65,363	329,089	8.00
9.00	Speech Pathology	31,783	0	2,780	0	7,665	42,228	9.00
10.00	Medical Social Services	85,164	0	428	0	1,179	86,771	10.00
11.00	Home Health Aide	188,480	0	36,447	0	100,487	325,414	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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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)	455	0	0	0	0	455	23.00
23.50	Tel emedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,156,765	0	305,508	0	842,307	4,304,580	24.00
		Reclassified	Reclassified	Adjustments	Net Expenses			
		7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-7,169	621,342	-9,911	611,431			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	1,760,993	0	1,760,993			6.00
7.00	Physical Therapy	0	1,131,119	0	1,131,119			7.00
8.00	Occupational Therapy	0	329,089	0	329,089			8.00
9.00	Speech Pathology	0	42,228	0	42,228			9.00
10.00	Medical Social Services	0	86,771	0	86,771			10.00
11.00	Home Health Aide	0	325,414	0	325,414			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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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	455	0	455			23.00
23.50	Tel emedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-7,169	4,297,411	-9,911	4,287,500			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: 14-0015 HHA CCN: 14-7031		Period: From 10/01/2017 To 09/30/2018		Worksheet H-1 Part I Date/Time Prepared: 2/27/2019 12:28 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	611,431	0	0	0	611,431	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	1,760,993	0	0	0	1,760,993	6.00
7.00	Physical Therapy	1,131,119	0	0	0	1,131,119	7.00
8.00	Occupational Therapy	329,089	0	0	0	329,089	8.00
9.00	Speech Pathology	42,228	0	0	0	42,228	9.00
10.00	Medical Social Services	86,771	0	0	0	86,771	10.00
11.00	Home Health Aide	325,414	0	0	0	325,414	11.00
12.00	Supplies (see instructions)	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	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	455	0	0	0	455	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,287,500	0	0	0	4,287,500	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
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	611,431					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	292,902	2,053,895				6.00
7.00	Physical Therapy	188,136	1,319,255				7.00
8.00	Occupational Therapy	54,736	383,825				8.00
9.00	Speech Pathology	7,024	49,252				9.00
10.00	Medical Social Services	14,432	101,203				10.00
11.00	Home Health Aide	54,125	379,539				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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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)	76	531				23.00
23.50	Telemedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		4,287,500				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet H-1

HHA CCN: 14-7031

To 09/30/2018

Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Home Health  
Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-611,431	3,676,069
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	1,760,993
7.00	Physical Therapy	0	0	0	0	0	1,131,119
8.00	Occupational Therapy	0	0	0	0	0	329,089
9.00	Speech Pathology	0	0	0	0	0	42,228
10.00	Medical Social Services	0	0	0	0	0	86,771
11.00	Home Health Aide	0	0	0	0	0	325,414
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	455
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-611,431	3,676,069
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	611,431
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.166327

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet H-2

HHA CCN: 14-7031

To 09/30/2018

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			NEW BLDG & FIXTURES	MOB PHASE I	
		BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES			
	0	1.00	1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	2,053,895	0	0	0	0	0	2.00
3.00 Physical Therapy	1,319,255	0	0	0	0	0	3.00
4.00 Occupational Therapy	383,825	0	0	0	0	0	4.00
5.00 Speech Pathology	49,252	0	0	0	0	0	5.00
6.00 Medical Social Services	101,203	0	0	0	0	0	6.00
7.00 Home Health Aide	379,539	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)	531	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)	4,287,500	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	CAPITAL RELATED COSTS				Subtotal	ADMINISTRATIVE & GENERAL	
	BBC	BEC	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT			
	1.05	1.06	2.00	4.00			
1.00 Administrative and General	0	37,717	3,455	87,640	128,812	39,927	1.00
2.00 Skilled Nursing Care	0	0	0	161,656	2,215,551	686,733	2.00
3.00 Physical Therapy	0	0	0	114,766	1,434,021	444,491	3.00
4.00 Occupational Therapy	0	0	0	33,468	417,293	129,345	4.00
5.00 Speech Pathology	0	0	0	4,432	53,684	16,640	5.00
6.00 Medical Social Services	0	0	0	11,875	113,078	35,050	6.00
7.00 Home Health Aide	0	0	0	26,282	405,821	125,789	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	63	594	184	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	37,717	3,455	440,182	4,768,854	1,478,159	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet H-2

HHA CCN: 14-7031

To 09/30/2018

Part I  
Date/Time Prepared: 2/27/2019 12:28 am

Home Health Agency I

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Cost Center Description		MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	47,043	0	20,746	0	0	788,326	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)	47,043	0	20,746	0	0	788,326	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		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	PARAMED PRGM-RADIOLOGY	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			21.00
1.00	Administrative and General	0	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)	0	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

(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: 14-0015

Period: From 10/01/2017

Worksheet H-2

HHA CCN: 14-7031

To 09/30/2018

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Home Health Agency I

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Cost Center Description		PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.02	23.03	23.04	23.05	24.00	25.00	
1.00	Administrative and General	0	0	0	0	1,024,854	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,902,284	0	2.00
3.00	Physical Therapy	0	0	0	0	1,878,512	0	3.00
4.00	Occupational Therapy	0	0	0	0	546,638	0	4.00
5.00	Speech Pathology	0	0	0	0	70,324	0	5.00
6.00	Medical Social Services	0	0	0	0	148,128	0	6.00
7.00	Home Health Aide	0	0	0	0	531,610	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	778	0	19.00
19.50	Telmedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	7,103,128	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	1,024,854						1.00
2.00	Skilled Nursing Care	2,902,284	489,354	3,391,638				2.00
3.00	Physical Therapy	1,878,512	316,734	2,195,246				3.00
4.00	Occupational Therapy	546,638	92,168	638,806				4.00
5.00	Speech Pathology	70,324	11,857	82,181				5.00
6.00	Medical Social Services	148,128	24,976	173,104				6.00
7.00	Home Health Aide	531,610	89,634	621,244				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	778	131	909				19.00
19.50	Telmedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	7,103,128	1,024,854	7,103,128				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.		0.168609					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: 14-0015  
HHA CCN: 14-7031

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					BBC (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04		
1.00	Administrative and General	0	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)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)				
		1.06	2.00	4.00				
1.00	Administrative and General	2,049	3,466	628,511	0	128,812	2,049	1.00
2.00	Skilled Nursing Care	0	0	1,159,308	0	2,215,551	0	2.00
3.00	Physical Therapy	0	0	823,045	0	1,434,021	0	3.00
4.00	Occupational Therapy	0	0	240,019	0	417,293	0	4.00
5.00	Speech Pathology	0	0	31,783	0	53,684	0	5.00
6.00	Medical Social Services	0	0	85,164	0	113,078	0	6.00
7.00	Home Health Aide	0	0	188,480	0	405,821	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	455	0	594	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,049	3,466	3,156,765	0	4,768,854	2,049	20.00
21.00	Total cost to be allocated	37,717	3,455	440,182	0	1,478,159	47,043	21.00
22.00	Unit cost multiplier	18.407516	0.996826	0.139441	0	0.309961	22.959004	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015  
HHA CCN: 14-7031

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/27/2019 12:28 am  
PPS

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	8.00	9.00	10.00	11.00	13.00	16.00	
1.00 Administrative and General	0	451	0	0	100,036	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)	0	451	0	0	100,036	0	20.00
21.00 Total cost to be allocated	0	20,746	0	0	788,326	0	21.00
22.00 Unit cost multiplier	0.000000	46.000000	0.000000	0.000000	7.880423	0.000000	22.00

Cost Center Description	INTERNS & RESIDENTS						
	NURSING SCHOOL	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	
	20.00	21.00	22.00	23.00	23.01	23.02	
1.00 Administrative and General	0	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)	0	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2017 To 09/30/2018	Worksheet H-2 Part II Date/Time Prepared: 2/27/2019 12:28 am PPS
		Home Health Agency I	

Cost Center Description	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATORY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)		
	23.03	23.04	23.05		
1.00 Administrative and General	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0		2.00
3.00 Physical Therapy	0	0	0		3.00
4.00 Occupational Therapy	0	0	0		4.00
5.00 Speech Pathology	0	0	0		5.00
6.00 Medical Social Services	0	0	0		6.00
7.00 Home Health Aide	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0		8.00
9.00 Drugs	0	0	0		9.00
10.00 DME	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0		13.00
14.00 Clinic	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0		15.00
16.00 Day Care Program	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0		17.00
18.00 Homemaker Service	0	0	0		18.00
19.00 All Others (specify)	0	0	0		19.00
19.50 Telemedicine	0	0	0		19.50
20.00 Total (sum of lines 1-19)	0	0	0		20.00
21.00 Total cost to be allocated	0	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0015 HHA CCN: 14-7031		Period: From 10/01/2017 To 09/30/2018		Worksheet H-3 Part I Date/Time Prepared: 2/27/2019 12:28 am	
				Title XVIII		Home Health Agency I		PPS	
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	3,391,638		3,391,638	23,997	141.34	1.00	
2.00	Physical Therapy	3.00	2,195,246	0	2,195,246	12,285	178.69	2.00	
3.00	Occupational Therapy	4.00	638,806	0	638,806	3,551	179.89	3.00	
4.00	Speech Pathology	5.00	82,181	0	82,181	416	197.55	4.00	
5.00	Medical Social Services	6.00	173,104		173,104	65	2,663.14	5.00	
6.00	Home Health Aide	7.00	621,244		621,244	5,461	113.76	6.00	
7.00	Total (sum of lines 1-6)		7,102,219	0	7,102,219	45,775		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		99914	0	11,928			8.00	
8.01	Skilled Nursing Care		99926	0	2,712			8.01	
8.02	Skilled Nursing Care		17860	0	5			8.02	
9.00	Physical Therapy		99914	0	6,605			9.00	
9.01	Physical Therapy		99926	0	1,980			9.01	
9.02	Physical Therapy		17860	0	8			9.02	
10.00	Occupational Therapy		99914	0	2,034			10.00	
10.01	Occupational Therapy		99926	0	300			10.01	
10.02	Occupational Therapy		17860	0	0			10.02	
11.00	Speech Pathology		99914	0	197			11.00	
11.01	Speech Pathology		99926	0	23			11.01	
11.02	Speech Pathology		17860	0	0			11.02	
12.00	Medical Social Services		99914	0	35			12.00	
12.01	Medical Social Services		99926	0	3			12.01	
12.02	Medical Social Services		17860	0	0			12.02	
13.00	Home Health Aide		99914	0	3,360			13.00	
13.01	Home Health Aide		99926	0	640			13.01	
13.02	Home Health Aide		17860	0	0			13.02	
14.00	Total (sum of lines 8-13)			0	29,830			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	0	0	190,188	0.000000	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00	
Cost Center Description		Part A	Program Visits		Cost of Services				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B	Not Subject to Deductibles & Coinsurance	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	14,645		0	2,069,924		1.00	
2.00	Physical Therapy	0	8,593		0	1,535,483		2.00	
3.00	Occupational Therapy	0	2,334		0	419,863		3.00	
4.00	Speech Pathology	0	220		0	43,461		4.00	
5.00	Medical Social Services	0	38		0	101,199		5.00	
6.00	Home Health Aide	0	4,000		0	455,040		6.00	
7.00	Total (sum of lines 1-6)	0	29,830		0	4,624,970		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2017 To 09/30/2018	Worksheet H-3 Part I Date/Time Prepared: 2/27/2019 12:28 am
				Title XVIII	Home Health Agency I	PPS

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	190,188	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 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	2,069,924						1.00
2.00	Physical Therapy	1,535,483						2.00
3.00	Occupational Therapy	419,863						3.00
4.00	Speech Pathology	43,461						4.00
5.00	Medical Social Services	101,199						5.00
6.00	Home Health Aide	455,040						6.00
7.00	Total (sum of lines 1-6)	4,624,970						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: 14-0015 HHA CCN: 14-7031		Period: From 10/01/2017 To 09/30/2018		Worksheet H-3 Part II Date/Time Prepared: 2/27/2019 12:28 am	
			Title XVIII		Home Health Agency I		PPS	
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	0.471912	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.328894	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.297611	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.163920	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.157864	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2017 To 09/30/2018	Worksheet H-4 Part I-11 Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	4,734,648	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	4,734,648	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	4,734,648	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	4,008,276
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	135,301
13.00	Total PPS Reimbursement - LUPA Episodes		0	59,676
14.00	Total PPS Reimbursement - PEP Episodes		0	25,231
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	74,191
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	157
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	4,302,832
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	4,302,832
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	4,302,832
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	4,302,832
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	4,302,832
31.01	Sequestration adjustment (see instructions)		0	86,057
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	4,216,775
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0015  
HHA CCN: 14-7031

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

Worksheet H-5  
Date/Time Prepared:  
2/27/2019 12:28 am  
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		4,216,775	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		4,216,775	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		4,216,775	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet 0

Hospice CCN: 14-1501

To 09/30/2018

Date/Time Prepared: 2/27/2019 12:28 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	269,673	65,447	335,120	0	335,120
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	63,991	63,991	0	63,991
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	12,534	12,534
14.00	PHARMACY*	0	0	0	0	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	33,787	33,787	0	33,787
27.00	NURSE PRACTITIONER**	33,335	731	34,066	0	34,066
28.00	REGISTERED NURSE**	437,635	0	437,635	0	437,635
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	130,083	0	130,083	0	130,083
34.00	SPIRITUAL COUNSELING**	66,813	0	66,813	0	66,813
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	83,347	0	83,347	0	83,347
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	60,506	60,506	0	60,506
39.00	PATIENT TRANSPORTATION**	0	3,855	3,855	0	3,855
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	1,695	1,695	0	1,695
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	23,207	23,207	-783	22,424
42.50	DRUGS CHARGED TO PATIENTS**	0	105,334	105,334	0	105,334
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	75,980	0	75,980	0	75,980
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	1,096,866	358,553	1,455,419	11,751	1,467,170

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet 0
		Hospice CCN: 14-1501	Date/Time Prepared: 2/27/2019 12:28 am	
		Hospice I		

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	-19	335,101	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	63,991	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	12,534	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>				
25.00	INPATIENT CARE-CONTRACTED**	121,849	121,849	25.00
26.00	PHYSICIAN SERVICES**	-33,787	0	26.00
27.00	NURSE PRACTITIONER**	0	34,066	27.00
28.00	REGISTERED NURSE**	0	437,635	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	130,083	33.00
34.00	SPIRITUAL COUNSELING**	0	66,813	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	83,347	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	60,506	38.00
39.00	PATIENT TRANSPORTATION**	0	3,855	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	1,695	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	22,424	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	105,334	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
<b>NONREIMBURSABLE COST CENTERS</b>				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	75,980	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	88,043	1,555,213	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 14-0015 Hospice CCN: 14-1501	Period: From 10/01/2017 To 09/30/2018	Worksheet 0-2 Date/Time Prepared: 2/27/2019 12:28 am
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		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	33,787	33,787	0	33,787	26.00
27.00	NURSE PRACTITIONER	33,335	731	34,066	0	34,066	27.00
28.00	REGISTERED NURSE	409,397	0	409,397	0	409,397	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	125,282	0	125,282	0	125,282	33.00
34.00	SPIRITUAL COUNSELING	64,605	0	64,605	0	64,605	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	83,286	0	83,286	0	83,286	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	60,506	60,506	0	60,506	38.00
39.00	PATIENT TRANSPORTATION	0	3,855	3,855	0	3,855	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	1,695	1,695	0	1,695	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	23,198	23,198	-783	22,415	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	105,294	105,294	0	105,294	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	715,905	229,066	944,971	-783	944,188	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	-33,787	0	26.00
27.00	NURSE PRACTITIONER	0	34,066	27.00
28.00	REGISTERED NURSE	0	409,397	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	125,282	33.00
34.00	SPIRITUAL COUNSELING	0	64,605	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	83,286	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	60,506	38.00
39.00	PATIENT TRANSPORTATION	0	3,855	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	1,695	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	22,415	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	105,294	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	-33,787	910,401	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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

Provider CCN: 14-0015

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

Worksheet 0-3

Hospice CCN: 14-1501

Date/Time Prepared:  
2/27/2019 12:28 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0 25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0 26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0 27.00
28.00	REGISTERED NURSE	251	0	251	0	251 28.00
29.00	LPN/LVN	0	0	0	0	0 29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	201	0	201	0	201 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0 34.00
35.00	DIETARY COUNSELING	0	0	0	0	0 35.00
36.00	COUNSELING - OTHER	0	0	0	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	61	0	61	0	61 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0 39.00
40.00	IMAGING SERVICES	0	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	9	9	0	9 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	40	40	0	40 42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0 46.00
100.00	TOTAL *	513	49	562	0	562 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	540	540	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	251	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	201	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	61	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	9	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	40	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	540	1,102	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0015 Hospice CCN: 14-1501	Period: From 10/01/2017 To 09/30/2018	Worksheet 0-4 Date/Time Prepared: 2/27/2019 12:28 am
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		SALARIES	OTHER	SubTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SubTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	27,987	0	27,987	0	27,987	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	4,600	0	4,600	0	4,600	33.00
34.00	SPIRITUAL COUNSELING	2,208	0	2,208	0	2,208	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	34,795	0	34,795	0	34,795	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	121,309	121,309	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	27,987	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	4,600	33.00
34.00	SPIRITUAL COUNSELING	0	2,208	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	121,309	156,104	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 14-0015

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

Worksheet 0-5

Hospice CCN: 14-1501

Date/Time Prepared: 2/27/2019 12:28 am

Descriptions	Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
	1.00	2.00	3.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	24,794	24,794	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0	154,355	154,355	3.00
4.00 ADMINISTRATIVE & GENERAL	335,101	537,585	872,686	4.00
5.00 PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00 HOUSEKEEPING	0	0	0	7.00
8.00 DIETARY	0	0	0	8.00
9.00 NURSING ADMINISTRATION	0	297,053	297,053	9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00 MEDICAL RECORDS	0	0	0	11.00
12.00 STAFF TRANSPORTATION	63,991	0	63,991	12.00
13.00 VOLUNTEER SERVICE COORDINATION	12,534	0	12,534	13.00
14.00 PHARMACY	0	0	0	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00 OTHER GENERAL SERVICE	0	20,566	20,566	16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
<b>LEVEL OF CARE</b>				
50.00 HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE	910,401	0	910,401	51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	1,102	0	1,102	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	156,104	0	156,104	53.00
<b>NONREIMBURSABLE COST CENTERS</b>				
60.00 BEREAVEMENT PROGRAM	0	0	0	60.00
61.00 VOLUNTEER PROGRAM	0	0	0	61.00
62.00 FUNDRAISING	0	0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00 PALLIATIVE CARE PROGRAM	75,980	0	75,980	64.00
65.00 OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00 RESIDENTIAL CARE	0	0	0	66.00
67.00 ADVERTISING	0	0	0	67.00
68.00 TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00 THRIFT STORE	0	0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	99.00
100.00 TOTAL	1,555,213	1,034,353	2,589,566	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,794		24,794		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	154,355	0	0	154,355	3.00
4.00	ADMINISTRATIVE & GENERAL	872,686	0	24,794	37,603	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	297,053	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	63,991	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	12,534	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	20,566	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	910,401			99,826	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	1,102	0	0	72	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	156,104	0	0	4,852	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	1,407	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	75,980	0	0	10,595	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	2,589,566	0	24,794	154,355	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL	935,083				4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0			5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	HOUSEKEEPING	0	0		0	7.00
8.00	DIETARY	0	0		0	8.00
9.00	NURSING ADMINISTRATION	167,889	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0	10.00
11.00	MEDICAL RECORDS	0	0		0	11.00
12.00	STAFF TRANSPORTATION	36,166	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	7,084	0		0	13.00
14.00	PHARMACY	0	0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	11,624	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	570,961				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	664	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	90,969	0	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0		0	60.00
61.00	VOLUNTEER PROGRAM	795	0		0	61.00
62.00	FUNDRAISING	0	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	48,931	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	68.00
69.00	THRIFT STORE	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	935,083	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet 0-6

Hospice CCN: 14-1501

To 09/30/2018

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	464,942					9.00
10.00	0	0				10.00
11.00	0		0			11.00
12.00	0			100,157		12.00
13.00	0			0	19,618	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						17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0	0	0	50.00
51.00	449,413	0	0	96,812	18,963	51.00
52.00	173	0	0	37	7	52.00
53.00	15,356	0	0	3,308	648	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0			0	0	60.00
61.00	0			0	0	61.00
62.00	0			0	0	62.00
63.00	0			0	0	63.00
64.00	0			0	0	64.00
65.00	0			0	0	65.00
66.00	0			0	0	66.00
67.00	0			0	0	67.00
68.00	0			0	0	68.00
69.00	0			0	0	69.00
70.00						70.00
71.00	0			0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	464,942	0	0	100,157	19,618	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part I  
Date/Time Prepared:  
2/27/2019 12:28 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00	0	0				15.00
16.00	0		32,190			16.00
17.00				0		17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0		0	50.00
51.00	0	0	32,190		2,178,566	51.00
52.00	0	0	0	0	2,055	52.00
53.00	0	0	0	0	271,237	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0		0		0	60.00
61.00	0		0		2,202	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		135,506	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	0	0	32,190	0	2,589,566	100.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	HOSPICE I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIX	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		24,871				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,106,956			3.00
4.00	ADMINISTRATIVE & GENERAL	0	24,871	269,673	-935,083	1,654,483	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	297,053	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	63,991	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	12,534	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	20,566	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			715,905	0	1,010,227	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	513	0	1,174	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	34,795	0	160,956	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	10,090	0	1,407	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	75,980	0	86,575	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	24,794	154,355		935,083	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.996904	0.139441		0.565181	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		37,695	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					36,436	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	14	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1,245	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)					464,942	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	12.334315	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS) 10.00	MEDICAL RECORDS (PATIENT DAYS) 11.00	STAFF TRANSPORTATION (MILEAGE) 12.00	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE) 13.00	PHARMACY (CHARGES) 14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			37,695			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	37,695		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	36,436	36,436	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	14	14	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,245	1,245	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	100,157	19,618	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	2.657037	0.520440	0.000000	101.00

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

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

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

Part II  
Date/Time Prepared:  
2/27/2019 12:28 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		160			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	160			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	32,190	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	201.187500	0.000000		101.00

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

Provider CCN: 14-0015

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

Worksheet 0-7

Hospice CCN: 14-1501

Date/Time Prepared: 2/27/2019 12:28 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.471912	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.328894	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.297611	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.157864	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.081929	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.163920	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.192592	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet 0-8

Hospice CCN: 14-1501

To 09/30/2018

Date/Time Prepared: 2/27/2019 12:28 am

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
<b>HOSPICE CONTINUOUS HOME CARE</b>				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	0
5.00	Program cost (line 3 times line 4)	0	0	0
<b>HOSPICE ROUTINE HOME CARE</b>				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,178,566
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			10,620
8.00	Total average cost per diem (line 6 divided by line 7)			205.14
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	9,695	475	10,170
10.00	Program cost (line 8 times line 9)	1,988,832	97,442	2,086,274
<b>HOSPICE INPATIENT RESPITE CARE</b>				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			2,055
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			4
13.00	Total average cost per diem (line 11 divided by line 12)			513.75
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	4	4
15.00	Program cost (line 13 times line 14)	0	2,055	2,055
<b>HOSPICE GENERAL INPATIENT CARE</b>				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			271,237
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			363
18.00	Total average cost per diem (line 16 divided by line 17)			747.21
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	300	26	326
20.00	Program cost (line 18 times line 19)	224,163	19,427	243,590
<b>TOTAL HOSPICE CARE</b>				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			2,451,858
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			10,987
23.00	Average cost per diem (line 21 divided by line 22)			223.16

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0015	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 12:28 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		4,249,948	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		203,285	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		136.19	3.00
4.00	Number of interns & residents (see instructions)		15.86	4.00
5.00	Indirect medical education percentage (see instructions)		3.34	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		141,948	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		4,595,181	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-0015 Component CCN: 14-3422		Period: From 10/01/2017 To 09/30/2018		Worksheet M-1 Date/Time Prepared: 2/27/2019 12:28 am	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	250,255	0	250,255	0	250,255	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	94,598	0	94,598	0	94,598	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	188,255	0	188,255	0	188,255	9.00
10.00	Subtotal (sum of lines 1 through 9)	533,108	0	533,108	0	533,108	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	199,014	199,014	0	199,014	12.00
13.00	Other Costs Under Agreement	0	171	171	0	171	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	199,185	199,185	0	199,185	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	57,827	57,827	-988	56,839	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	57,827	57,827	-988	56,839	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	533,108	257,012	790,120	-988	789,132	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	90,795	90,795	0	90,795	29.00
30.00	Administrative Costs	76,889	28,420	105,309	0	105,309	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	76,889	119,215	196,104	0	196,104	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	609,997	376,227	986,224	-988	985,236	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period: From 10/01/2017

Worksheet M-1

Component CCN: 14-3422

To 09/30/2018

Date/Time Prepared: 2/27/2019 12:28 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC 1	Cost
		6.00	7.00		
<b>FACILITY HEALTH CARE STAFF COSTS</b>					
1.00	Physician	0	250,255		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	94,598		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	188,255		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	533,108		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	199,014		12.00
13.00	Other Costs Under Agreement	0	171		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	199,185		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	56,839		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,839		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	789,132		22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>					
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
<b>FACILITY OVERHEAD</b>					
29.00	Facility Costs	-47,691	43,104		29.00
30.00	Administrative Costs	-215	105,094		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-47,906	148,198		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-47,906	937,330		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2017 To 09/30/2018	Worksheet M-2 Date/Time Prepared: 2/27/2019 12:28 am
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	1.39	3,122	4,200	5,838	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.90	3,965	2,100	1,890	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.29	7,087		7,728	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	0.10	110		110	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.39	7,197		7,838	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				789,132	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)				789,132	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)				148,198	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				401,960	15.00
16.00	Total overhead (sum of lines 14 and 15)				550,158	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				550,158	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				550,158	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,339,290	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII	RHC I	Cost	
				1.00	
<b>DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES</b>					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,339,290	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			37,589	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,301,701	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,838	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)			7,838	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			166.08	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)	82.30	83.45		9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)	534	1,563		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	43,948	130,432		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	25		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,086		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,086		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	176,466		16.00
16.01	Total program charges (see instructions)(from contractor's records)		473,595		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		831		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		310		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.)		109,216		16.04
16.05	Total program cost (see instructions)	0	109,526		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,636		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		86,626		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		109,526		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,009		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		131,535		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		131,535		26.00
26.01	Sequestration adjustment (see instructions)		2,631		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		103,414		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)		25,490		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: 14-0015 Component CCN: 14-3422	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 12:28 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		533,108	533,108	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000536	0.005636	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		286	3,005	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,045	6,812	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		12,331	9,817	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		789,132	789,132	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		550,158	550,158	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015626	0.012440	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,597	6,844	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		20,928	16,661	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		95	494	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		220.29	33.73	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		65	228	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		14,319	7,690	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)			37,589	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)			22,009	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 12:28 am
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		103,414	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		103,414	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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		25,490	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		128,904	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00