

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: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/30/2018 10:33 am
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**PART I - COST REPORT STATUS**

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

Date: 11/30/2018 Time: 10:33 am

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

6. Date Received:  
 7. Contractor No.

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

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

**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 GREENVILLE REGIONAL HOSPITAL ( 14-0137 ) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V	Title XVIII		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	34,414	-21,028	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
10.00 RURAL HEALTH CLINIC I	0	0	-101,137		0	10.00
200.00 Total	0	34,414	-122,165	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: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/30/2018 10:31 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 HEALTHCARE DRIVE	PO Box:		1.00
2.00	City: GREENVILLE	State: IL	Zip Code: 62246-1156	2.00
County: BOND				

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519	41180		07/24/2007	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

					From:		To:		
					1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)				07/01/2017		06/30/2018		20.00
21.00	Type of Control (see instructions)				2				21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickles 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)					Y	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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3			N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
24.00	916	0	0	0	0	32	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/30/2018 10:31 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	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)					Y	N	40.00	
		V		XVII		XIX			
		1.00		2.00		3.00			
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
		NAHE 413.85 Y/N		Worksheet A Line #		Pass-Through Qualification Criterion Code			
		1.00		2.00		3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0137

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					Y		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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			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.			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 1.00	XIX 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.		Y	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.		Y	Y 98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N 98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N 98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.06
<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)		N	106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	108.00
			Physical 1.00	Occupational 2.00
			Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/30/2018 10:31 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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:	216	0	311,514		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
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		148005		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/30/2018 10:31 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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131																																									
142.00	Street: 4936 LAVERNA ROAD	PO Box:																																											
143.00	City: SPRINGFIELD	State: IL	Zip Code:	62794																																									
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.																																													
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)																																													
0.00																																													
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)																																													
168.01																																													
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)																																													
0.00																																													
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>12/01/2017</td> <td>02/28/2018</td> </tr> </tbody> </table>						Beginning	Ending	1.00	2.00	12/01/2017	02/28/2018																																		
Beginning	Ending																																												
1.00	2.00																																												
12/01/2017	02/28/2018																																												
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																																													
0.00																																													

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/30/2018 10:31 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.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	10/10/2018	Y	10/10/2018		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: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/30/2018 10:31 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.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<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.		N		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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
<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.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PRACHELL@BKD.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0137

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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	32	11,680	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)		32	11,680	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		32	11,680	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		42				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: 14-0137

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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)	834	754	2,050			1.00
2.00 HMO and other (see instructions)	88	0				2.00
3.00 HMO IPF Subprovider	46	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	753	0	1,044			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	170			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,587	754	3,264			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		162	311			13.00
14.00 Total (see instructions)	1,587	916	3,575	0.00	180.07	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,154	75	1,518	0.00	15.18	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	4,655	2,949	16,058	0.00	9.38	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	204.63	27.00
28.00 Observation Bed Days		39	218			28.00
29.00 Ambulance Trips	647					29.00
30.00 Employee discount days (see instruction)			5			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	32	74			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: 14-0137

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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	295	308	838	1.00
2.00 HMO and other (see instructions)			33	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	295	308	838	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	126	9	175	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part II Date/Time Prepared: 11/30/2018 10:31 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	10,475,983	0	10,475,983	403,577.08	25.96	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		411,345	0	411,345	3,720.00	110.58	3.00
4.00	Physician-Part A - Administrative		6,000	0	6,000	59.01	101.68	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		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,625,633	0	1,625,633	67,062.43	24.24	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract Labor: Direct Patient Care		1,274,706	0	1,274,706	18,192.55	70.07	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		22,298	0	22,298	219.29	101.68	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		573,832	0	573,832	6,214.79	92.33	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)		2,348,739	0	2,348,739			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		465,967	0	465,967			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		58,032	0	58,032			21.00
22.00	Physician Part A - Administrative		868	0	868			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		150,647	0	150,647			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	31,295	0	31,295	1,361.70	22.98	26.00
27.00	Administrative & General	5.00	1,365,556	0	1,365,556	50,916.71	26.82	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/30/2018 10:31 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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	282,327	0	282,327	10,460.95	26.99	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	377,371	0	377,371	28,631.67	13.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	381,248	-254,338	126,910	4,140.67	30.65	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	254,338	254,338	22,714.73	11.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	623,891	0	623,891	19,506.34	31.98	38.00
39.00	Central Services and Supply	14.00	116,855	0	116,855	5,276.42	22.15	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	200,479	0	200,479	11,262.66	17.80	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/30/2018 10:31 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet 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 III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	10,064,638	0	10,064,638	399,857.08	25.17	1.00
2.00	Excluded area salaries (see instructions)	1,625,633	0	1,625,633	67,062.43	24.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)	8,439,005	0	8,439,005	332,794.65	25.36	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,870,836	0	1,870,836	24,626.63	75.97	4.00
5.00	Subtotal wage-related costs (see inst.)	2,500,254	0	2,500,254	0.00	29.63	5.00
6.00	Total (sum of lines 3 thru 5)	12,810,095	0	12,810,095	357,421.28	35.84	6.00
7.00	Total overhead cost (see instructions)	3,379,022	0	3,379,022	154,271.85	21.90	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2018 10:31 am
				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			116,499 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)			131,435 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			1,125 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			3,359 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)			1,613,076 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			83 9.00
10.00	Dental, Hearing and Vision Plan			43,449 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			50,980 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)			8,016 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			126,745 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			549,866 17.00
18.00	Medicare Taxes - Employers Portion Only			151,902 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			41,090 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			35,980 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			2,873,605 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: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/30/2018 10:31 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		3,827,255	2,873,605
2.00	Hospital		1,274,706	2,873,605
3.00	Subprovider - IPF		840	0
4.00	Subprovider - IRF			0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	0
9.00	Hospital-Based NF		0	0
10.00	Hospital-Based OLTC			0
11.00	Hospital-Based HHA			0
12.00	Separately Certified ASC			0
13.00	Hospital-Based Hospice			0
14.00	Hospital-Based Health Clinic RHC		2,551,709	0
15.00	Hospital-Based Health Clinic FQHC			0
16.00	Hospital-Based-CMHC			0
17.00	Renal Dialysis			0
18.00	Other		0	0

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0137

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

Worksheet S-7  
Date/Time Prepared:  
11/30/2018 10:31 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	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	6	5.00
6.00		RVL	0	24	6.00
7.00		RHX	0	7	7.00
8.00		RHL	0	48	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	0	0	12.00
13.00		RUB	0	30	13.00
14.00		RUA	0	95	14.00
15.00		RVC	0	0	15.00
16.00		RVB	0	105	16.00
17.00		RVA	0	334	17.00
18.00		RHC	0	0	18.00
19.00		RHB	0	14	19.00
20.00		RHA	0	47	20.00
21.00		RMC	0	11	21.00
22.00		RMB	0	0	22.00
23.00		RMA	0	6	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	4	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	14	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	2	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	0	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	0	6	52.00
53.00		CA2	0	0	53.00
54.00		CA1	0	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0137

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

Worksheet S-7

Date/Time Prepared:  
11/30/2018 10:31 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	753	753	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).  
 41180 41180 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0137 Component CCN: 14-8519		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/30/2018 10:31 am	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		201 HEALTHCARE DRIVE		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		GREENVILLE IL62246		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		Grant Award		Date	
				1.00		2.00	
4.00	4.00	Source of Federal Funds					
5.00	5.00	Community Health Center (Section 330(d), PHS Act)					
6.00	6.00	Migrant Health Center (Section 329(d), PHS Act)					
7.00	7.00	Health Services for the Homeless (Section 340(d), PHS Act)					
8.00	8.00	Appalachian Regional Commission					
9.00	9.00	Look-Alikes					
9.00	9.00	OTHER (SPECIFY)					
				1.00		2.00	
10.00	10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0	
				1.00		2.00	
				Sunday		Monday	
				Tuesday			
				from		from	
				to		to	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1)		CLINIC		08:00 17:00 08:00	
						1.00 2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N			
13.00	13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y		4	
				1.00		2.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number		MCCRACKEN DAWDY HALL FAMILY PRACTICE		148519	
14.01	14.01			MCCRACKEN DAWDY HALL FAMILY PRACTICE		148520	
14.02	14.02			GREENVILLE MEDICAL ASSOCIATES		148513	
14.03	14.03			CONVENIENT CARE		148545	
				Y/N		V	
				XVIII		XIX	
				1.00		2.00	
				3.00		4.00	
				Total Visits		5.00	
15.00	15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0137  
Component CCN: 14-8519

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

Worksheet S-8

Date/Time Prepared:  
11/30/2018 10:31 am

		RHC I			Cost		
		County					
		4.00					
2.00	City, State, ZIP Code, County	BOND			2.00		
		Tuesday		Wednesday		Thursday	
		to		to		to	
		6.00		7.00		8.00	
		9.00		10.00			
Facility hours of operations (1)							
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from		from		to	
		11.00		12.00		13.00	
		14.00					
Facility hours of operations (1)							
11.00	CLINIC	08:00	17:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/30/2018 10:31 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)		0.401369	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,288,572	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,807,910	5.00	
6.00	Medicaid charges		12,017,504	6.00	
7.00	Medicaid cost (line 1 times line 6)		4,823,454	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)		726,972	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)		726,972	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)	406,063	445,035	851,098	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	162,981	445,035	608,016	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	162,981	445,035	608,016	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,890,855	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		125,340	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		192,831	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		1,698,024	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		749,025	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,357,041	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,084,013	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0137

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

Worksheet A

Date/Time Prepared:  
11/30/2018 10:31 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		652,425	652,425	-265,492	386,933	1.00
2.00	00200		615,243	615,243	451,534	1,066,777	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	31,295	2,895,017	2,926,312	0	2,926,312	4.00
5.00	00500	1,365,556	4,453,811	5,819,367	-28,042	5,791,325	5.00
6.00	00600	282,327	904,543	1,186,870	0	1,186,870	6.00
8.00	00800	0	117,139	117,139	0	117,139	8.00
9.00	00900	377,371	71,659	449,030	0	449,030	9.00
10.00	01000	381,248	246,010	627,258	-418,456	208,802	10.00
11.00	01100	0	0	0	418,456	418,456	11.00
13.00	01300	623,891	81,450	705,341	0	705,341	13.00
14.00	01400	116,855	23,447	140,302	0	140,302	14.00
16.00	01600	200,479	151,687	352,166	0	352,166	16.00
19.00	01900	0	0	0	586,627	586,627	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,425,473	1,563,980	2,989,453	-702,091	2,287,362	30.00
40.00	04000	809,706	246,505	1,056,211	0	1,056,211	40.00
43.00	04300	0	0	0	568,874	568,874	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	686,558	378,390	1,064,948	32,797	1,097,745	50.00
52.00	05200	0	0	0	133,217	133,217	52.00
53.00	05300	411,345	208,079	619,424	-619,424	0	53.00
54.00	05400	608,856	544,932	1,153,788	0	1,153,788	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	579,702	900,162	1,479,864	0	1,479,864	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	269,820	16,376	286,196	-77,732	208,464	65.00
66.00	06600	0	1,041,318	1,041,318	-290,293	751,025	66.00
67.00	06700	0	0	0	178,758	178,758	67.00
68.00	06800	0	0	0	111,535	111,535	68.00
69.00	06900	0	24,180	24,180	77,732	101,912	69.00
71.00	07100	0	487,029	487,029	0	487,029	71.00
72.00	07200	0	65,363	65,363	0	65,363	72.00
73.00	07300	522,375	937,663	1,460,038	0	1,460,038	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	45,723	20,717	66,440	0	66,440	75.01
76.97	07697	0	336	336	0	336	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	157,897	2,739,668	2,897,565	0	2,897,565	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	763,579	982,977	1,746,556	0	1,746,556	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	567,864	68,579	636,443	0	636,443	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	158,000	158,000	-158,000	0	113.00
118.00		10,227,920	20,596,685	30,824,605	0	30,824,605	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	161,841	345,632	507,473	0	507,473	192.00
193.00	19300	0	9,036	9,036	0	9,036	193.00
194.00	07950	86,222	157,552	243,774	0	243,774	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		10,475,983	21,108,905	31,584,888	0	31,584,888	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0137

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

Worksheet A  
Date/Time Prepared:  
11/30/2018 10:31 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	857,188	1,244,121	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,405	1,061,372	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-469,169	2,457,143	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,986,684	3,804,641	5.00
6.00	00600	MAINTENANCE & REPAIRS	-14,042	1,172,828	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,139	8.00
9.00	00900	HOUSEKEEPING	-22	449,008	9.00
10.00	01000	DIETARY	-2,342	206,460	10.00
11.00	01100	CAFETERIA	-120,072	298,384	11.00
13.00	01300	NURSING ADMINISTRATION	-190	705,151	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	140,302	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,719	350,447	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-586,627	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-649,485	1,637,877	30.00
40.00	04000	SUBPROVIDER - IPF	-210,938	845,273	40.00
43.00	04300	NURSERY	0	568,874	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,097,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	133,217	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,619	1,150,169	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-363,838	1,116,026	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	208,464	65.00
66.00	06600	PHYSICAL THERAPY	0	751,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,758	67.00
68.00	06800	SPEECH PATHOLOGY	0	111,535	68.00
69.00	06900	ELECTROCARDIOLOGY	-13,632	88,280	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-1,401	485,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-23,347	1,436,691	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	66,440	75.01
76.97	07697	CARDIAC REHABILITATION	0	336	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	398,187	3,295,752	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-948,759	797,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-27,388	609,055	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,173,304	26,651,301	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	151,228	658,701	192.00
193.00	19300	NONPAID WORKERS	0	9,036	193.00
194.00	07950	EMERALD POINT	208,477	452,251	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,813,599	27,771,289	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CRNA FEES</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	411,345	175,282	1.00
2.00	OPERATING ROOM	50.00	0	32,797	2.00
	O		411,345	208,079	
<b>B - CAFETERIA EXPENSE</b>					
1.00	CAFETERIA	11.00	254,338	164,118	1.00
	O		254,338	164,118	
<b>C - DEPRECIATION EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	444,622	1.00
	O		0	444,622	
<b>D - EKG SALARIES</b>					
1.00	ELECTROCARDIOLOGY	69.00	77,732	0	1.00
	O		77,732	0	
<b>E - OB EXPENSE</b>					
1.00	NURSERY	43.00	264,110	304,764	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	61,848	71,369	2.00
	O		325,958	376,133	
<b>F - CONTRACT THERAPY EXPENSE</b>					
1.00	OCCUPATIONAL THERAPY	67.00	0	178,758	1.00
2.00	SPEECH PATHOLOGY	68.00	0	111,535	2.00
	O		0	290,293	
<b>G - PROPERTY INSURANCE</b>					
1.00	OTHER CAP REL COSTS	3.00	0	28,042	1.00
	O		0	28,042	
<b>H - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	156,767	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,233	2.00
	O		0	158,000	
500.00	Grand Total: Increases		1,069,373	1,669,287	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CRNA FEES</b>							
1.00	ANESTHESIOLOGY	53.00	411,345	208,079	0		1.00
2.00		0.00	0	0	0		2.00
			411,345	208,079			
<b>B - CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	254,338	164,118	0		1.00
			254,338	164,118			
<b>C - DEPRECIATION EXPENSE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	444,622	9		1.00
			0	444,622			
<b>D - EKG SALARIES</b>							
1.00	RESPIRATORY THERAPY	65.00	77,732	0	0		1.00
			77,732	0			
<b>E - OB EXPENSE</b>							
1.00	ADULTS & PEDIATRICS	30.00	325,958	376,133	0		1.00
2.00		0.00	0	0	0		2.00
			325,958	376,133			
<b>F - CONTRACT THERAPY EXPENSE</b>							
1.00	PHYSICAL THERAPY	66.00	0	290,293	0		1.00
2.00		0.00	0	0	0		2.00
			0	290,293			
<b>G - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,042	12		1.00
			0	28,042			
<b>H - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	158,000	11		1.00
2.00		0.00	0	0	11		2.00
			0	158,000			
500.00	Grand Total: Decreases		1,069,373	1,669,287			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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	1,540,441	0	0	0	1.00
2.00	Land Improvements	406,675	0	0	0	2.00
3.00	Buildings and Fixtures	6,269,539	259,440	0	259,440	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	972,216	364,287	0	364,287	6.00
7.00	HIT designated Assets	815,874	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,004,745	623,727	0	623,727	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,004,745	623,727	0	623,727	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	1,540,441	0			1.00
2.00	Land Improvements	406,675	0			2.00
3.00	Buildings and Fixtures	6,528,979	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,336,503	0			6.00
7.00	HIT designated Assets	815,874	0			7.00
8.00	Subtotal (sum of lines 1-7)	10,628,472	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	10,628,472	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/30/2018 10:31 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	585,398	55,800	0	0	11,227	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	615,243	0	0	0	2.00
3.00	Total (sum of lines 1-2)	585,398	671,043	0	0	11,227	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	652,425				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	615,243				2.00
3.00	Total (sum of lines 1-2)	0	1,267,668				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part III Date/Time Prepared: 11/30/2018 10:31 am
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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	8,476,095	0	8,476,095	0.797490	22,363	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,152,377	0	2,152,377	0.202510	5,679	2.00
3.00	Total (sum of lines 1-2)	10,628,472	0	10,628,472	1.000000	28,042	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	22,363	1,004,969	55,800	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,679	439,272	615,243	2.00
3.00	Total (sum of lines 1-2)	0	0	28,042	1,444,241	671,043	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	149,762	22,363	11,227	0	1,244,121	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,178	5,679	0	0	1,061,372	2.00
3.00	Total (sum of lines 1-2)	150,940	28,042	11,227	0	2,305,493	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0137

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

Worksheet A-8

Date/Time Prepared:  
11/30/2018 10:31 am

Line #	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		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,005	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-55	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-2,400	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-14,042	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,049,309			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	-523,446			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-120,072	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	B	-1,401	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,719	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-962	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-586,627	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	COUNTRY CLUB DUES	A	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.00

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	
33.01 CRNA RELATED BENEFITS	A	-26,278	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01
33.02 LOBBYING EXPENSE	A	-13,290	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 ADVERTISING OFFSET	A	-59,387	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 AMBULANCE REIMBURSEMENT	B	-27,388	AMBULANCE SERVICES	95.00	0 33.04
33.05 EDUCATION SEMINARS	B	-190	NURSING ADMINISTRATION	13.00	0 33.05
33.06 PROVIDER TAX	A	-916,981	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.08 HEALTH FAIR EXP ADJ	A	-35,668	LABORATORY	60.00	0 33.08
33.09 MISC REVENUE	B	2,959	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 SELF INSURANCE ADJUSTMENT	A	-371,386	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 RENT	B	-3,250	RADIOLOGY-DIAGNOSTIC	54.00	0 33.11
33.12 COMMUNITY HEALTH EVENTS INCOME	B	-140,334	LABORATORY	60.00	0 33.12
33.13 TELEPHONE SERVICE	A	-5,350	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.13
33.14 TELEPHONE SERVICE	A	-3,740	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 TELEPHONE SERVICE	A	-457	CAP REL COSTS-BLDG & FIXT	1.00	9 33.15
33.16 CATERING REVENUE	B	-1,380	DIETARY	10.00	0 33.16
33.17 MISC REVENUE	B	-22	HOUSEKEEPING	9.00	0 33.17
33.18 MISC SUPPLY REVENUE	B	-23,347	DRUGS CHARGED TO PATIENTS	73.00	0 33.18
33.19 REVALUED ASSETS DEPRECIATION	A	813,738	CAP REL COSTS-BLDG & FIXT	1.00	9 33.19
33.20 REVALUED ASSETS DEPRECIATION	A	151,228	PHYSICIANS PRIVATE OFFICES	192.00	0 33.20
33.21 REVALUED ASSETS DEPRECIATION	A	208,477	EMERALD POINT	194.00	0 33.21
33.22 ALCHOLIC BEVERAGES	A	-246	ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23 FOOD COSTS FOR ADMINISTRATION	A	-5	ADMINISTRATIVE & GENERAL	5.00	0 33.23
33.24 DEFINED PENSION	A	-54,164	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.24
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,813,599			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: 14-0137

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

Worksheet A-8-1

Date/Time Prepared:  
11/30/2018 10:31 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	1.00	CAP REL COSTS-BLDG & FIXT	GFW RHC LEASE EXPENSE	10,000	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	GMA RHC LEASE EXPENSE	15,000	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH RHC LEASE EXPENSE	20,000	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH POKEY RHC LEASE EXPENSE	5,912	0
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	2,003,390	2,020,731
4.02	5.00	ADMINISTRATIVE & GENERAL	HSWS HOME OFFICE ALLOCATIONS	794,217	1,749,421
4.03	88.00	RURAL HEALTH CLINIC	RHC MANAGEMENT FEES	398,187	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,246,706	3,770,152

\* 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	B	0.00	HSWS	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0137

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

Worksheet A-8-1

Date/Time Prepared:  
11/30/2018 10:31 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	10,000	9		1.00
2.00	15,000	9		2.00
3.00	20,000	9		3.00
4.00	5,912	9		4.00
4.01	-17,341	0		4.01
4.02	-955,204	0		4.02
4.03	398,187	0		4.03
5.00	-523,446			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>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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	CORP OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0137

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

Worksheet A-8-2

Date/Time Prepared:  
11/30/2018 10:31 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	54.00	RADIOLOGY-DIAGNOSTIC	369	369	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	13,632	13,632	0	0	0	2.00
3.00	91.00	EMERGENCY	948,759	948,759	0	0	0	3.00
4.00	60.00	LABORATORY	187,836	187,836	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	231,247	210,932	20,315	181,300	233	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	38,290	38,290	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	649,485	649,485	0	0	0	7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	9,717	0	9,717	211,500	96	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,079,335	2,049,303	30,032		329	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	20,309	1,015	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	9,762	488	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			30,071	1,503	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	369		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	13,632		2.00
3.00	91.00	EMERGENCY	0	0	0	948,759		3.00
4.00	60.00	LABORATORY	0	0	0	187,836		4.00
5.00	40.00	SUBPROVIDER - IPF	0	20,309	6	210,938		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	38,290		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	649,485		7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	0	9,762	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	30,071	6	2,049,309		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,244,121	1,244,121			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,061,372		1,061,372		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,457,143	1,473	1,256	2,459,872	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,804,641	319,865	272,883	334,287	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,172,828	101,017	86,179	69,234	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	117,139	17,616	15,029	0	8.00
9.00 00900	HOUSEKEEPING	449,008	16,344	13,943	92,542	9.00
10.00 01000	DIETARY	206,460	30,751	26,234	93,493	10.00
11.00 01100	CAFETERIA	298,384	8,563	7,305	62,371	11.00
13.00 01300	NURSING ADMINISTRATION	705,151	17,871	15,246	90,625	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	140,302	56,922	48,560	28,656	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	350,447	21,516	18,356	49,163	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,637,877	75,502	64,411	269,632	30.00
40.00 04000	SUBPROVIDER - IPF	845,273	40,778	34,788	198,563	40.00
43.00 04300	NURSERY	568,874	18,616	15,882	64,767	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,097,745	72,711	62,030	168,363	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	133,217	4,363	3,722	15,167	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,150,169	53,186	45,373	149,309	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,116,026	23,070	19,682	142,159	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	208,464	13,117	11,190	47,105	65.00
66.00 06600	PHYSICAL THERAPY	751,025	41,178	35,129	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	178,758	9,699	8,274	0	67.00
68.00 06800	SPEECH PATHOLOGY	111,535	6,054	5,165	0	68.00
69.00 06900	ELECTROCARDIOLOGY	88,280	1,164	993	19,062	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	485,628	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	65,363	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,436,691	9,435	8,049	128,101	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	66,440	18,344	15,649	11,213	75.01
76.97 07697	CARDIAC REHABILITATION	336	3,600	3,071	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	3,295,752	170,865	145,766	38,721	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	797,797	20,762	17,712	187,251	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	609,055	19,353	16,510	139,256	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	26,651,301	1,193,735	1,018,387	2,399,040	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	658,701	45,350	38,689	39,688	192.00
193.00 19300	NONPAID WORKERS	9,036	5,036	4,296	0	193.00
194.00 07950	EMERALD POINT	452,251	0	0	21,144	194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	27,771,289	1,244,121	1,061,372	2,459,872	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,731,676					5.00
6.00	00600	293,528	1,722,786				6.00
8.00	00800	30,761	36,932	217,477			8.00
9.00	00900	117,439	34,264	0	723,540		9.00
10.00	01000	73,305	64,469	311	28,243	523,266	10.00
11.00	01100	77,347	17,951	1,510	7,864	0	11.00
13.00	01300	170,231	37,466	0	16,413	0	13.00
14.00	01400	56,362	119,333	0	52,278	0	14.00
16.00	01600	90,257	45,107	0	19,761	0	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	420,481	158,285	73,631	69,343	216,120	30.00
40.00	04000	229,893	85,489	29,198	37,451	68,653	40.00
43.00	04300	137,216	39,028	11,117	17,098	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	287,694	152,435	22,877	66,780	0	50.00
52.00	05200	32,134	9,147	2,602	4,007	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	287,116	111,501	0	48,847	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	267,175	48,366	0	21,189	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	57,478	27,499	13,851	12,047	0	65.00
66.00	06600	169,910	86,327	9,378	37,819	0	66.00
67.00	06700	40,403	20,334	0	8,908	0	67.00
68.00	06800	25,210	12,692	0	5,560	0	68.00
69.00	06900	22,488	2,439	7,923	1,069	0	69.00
71.00	07100	99,734	0	0	0	0	71.00
72.00	07200	13,424	0	0	0	0	72.00
73.00	07300	324,954	19,781	0	8,666	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	22,929	38,456	0	16,847	0	75.01
76.97	07697	1,439	7,546	0	3,306	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	749,837	358,210	1,801	156,926	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	210,202	43,526	30,894	19,068	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	161,047	40,572	6,017	17,774	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		4,469,994	1,617,155	211,110	677,264	284,773	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	160,688	95,074	6,215	41,651	0	192.00
193.00	19300	3,772	10,557	0	4,625	0	193.00
194.00	07950	97,222	0	152	0	238,493	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,731,676	1,722,786	217,477	723,540	523,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	481,295					11.00
13.00	01300	36,710	1,089,713				13.00
14.00	01400	9,929	0	512,342			14.00
16.00	01600	20,574	0	585	615,766		16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	90,202	456,014	12,120	28,741	0	30.00
40.00	04000	59,431	300,461	2,546	17,448	0	40.00
43.00	04300	16,251	82,158	2,507	2,617	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	45,841	0	36,109	41,830	0	50.00
52.00	05200	3,805	0	587	4,619	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	34,971	0	36,430	178,588	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	45,342	0	139,786	113,726	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	16,550	0	4,748	15,277	0	65.00
66.00	06600	0	0	3,032	42,505	0	66.00
67.00	06700	0	0	0	7,572	0	67.00
68.00	06800	0	0	0	2,456	0	68.00
69.00	06900	6,180	0	0	11,086	0	69.00
71.00	07100	0	0	164,014	11,716	0	71.00
72.00	07200	0	0	22,012	2,056	0	72.00
73.00	07300	19,983	0	0	56,025	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	5,098	25,775	73	1,188	0	75.01
76.97	07697	1,140	0	107	1,695	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	6,052	0	51,994	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	44,565	225,305	8,592	52,828	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	11,705	23,793	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		462,624	1,089,713	496,947	615,766	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	10,385	0	2,652	0	0	192.00
193.00	19300	0	0	758	0	0	193.00
194.00	07950	8,286	0	11,985	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		481,295	1,089,713	512,342	615,766	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
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
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,572,359	0	3,572,359	30.00
40.00	04000	1,949,972	0	1,949,972	40.00
43.00	04300	976,131	0	976,131	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,054,415	0	2,054,415	50.00
52.00	05200	213,370	0	213,370	52.00
53.00	05300	0	0	0	53.00
54.00	05400	2,095,490	0	2,095,490	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	1,936,521	0	1,936,521	60.00
60.01	06001	0	0	0	60.01
65.00	06500	427,326	0	427,326	65.00
66.00	06600	1,176,303	0	1,176,303	66.00
67.00	06700	273,948	0	273,948	67.00
68.00	06800	168,672	0	168,672	68.00
69.00	06900	160,684	0	160,684	69.00
71.00	07100	761,092	0	761,092	71.00
72.00	07200	102,855	0	102,855	72.00
73.00	07300	2,011,685	0	2,011,685	73.00
75.00	07500	0	0	0	75.00
75.01	07501	222,012	0	222,012	75.01
76.97	07697	22,240	0	22,240	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	4,975,924	0	4,975,924	88.00
90.00	09000	0	0	0	90.00
91.00	09100	1,658,502	0	1,658,502	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	1,045,082	0	1,045,082	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	0	113.00
118.00		25,804,583	0	25,804,583	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	1,099,093	0	1,099,093	192.00
193.00	19300	38,080	0	38,080	193.00
194.00	07950	829,533	0	829,533	194.00
194.01	07951	0	0	0	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		27,771,289	0	27,771,289	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/30/2018 10:31 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,473	1,256	2,729	2,729 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,570	319,865	272,883	608,318	370 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	101,017	86,179	187,196	77 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	17,616	15,029	32,645	0 8.00
9.00 00900	HOUSEKEEPING	0	16,344	13,943	30,287	103 9.00
10.00 01000	DIETARY	0	30,751	26,234	56,985	104 10.00
11.00 01100	CAFETERIA	0	8,563	7,305	15,868	69 11.00
13.00 01300	NURSING ADMINISTRATION	0	17,871	15,246	33,117	101 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	56,922	48,560	105,482	32 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	21,516	18,356	39,872	55 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	75,502	64,411	139,913	299 30.00
40.00 04000	SUBPROVIDER - IPF	0	40,778	34,788	75,566	220 40.00
43.00 04300	NURSERY	0	18,616	15,882	34,498	72 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	72,711	62,030	134,741	187 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	4,363	3,722	8,085	17 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	53,186	45,373	98,559	166 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	23,070	19,682	42,752	158 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	13,117	11,190	24,307	52 65.00
66.00 06600	PHYSICAL THERAPY	0	41,178	35,129	76,307	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	9,699	8,274	17,973	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	6,054	5,165	11,219	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,164	993	2,157	21 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	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	9,435	8,049	17,484	142 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	0	18,344	15,649	33,993	12 75.01
76.97 07697	CARDIAC REHABILITATION	0	3,600	3,071	6,671	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	170,865	145,766	316,631	43 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	20,762	17,712	38,474	208 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	19,353	16,510	35,863	154 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15,570	1,193,735	1,018,387	2,227,692	2,662 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	45,350	38,689	84,039	44 192.00
193.00 19300	NONPAID WORKERS	0	5,036	4,296	9,332	0 193.00
194.00 07950	EMERALD POINT	73,295	0	0	73,295	23 194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	88,865	1,244,121	1,061,372	2,394,358	2,729 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/30/2018 10:31 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		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
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	608,688			5.00
6.00	00600	MAINTENANCE & REPAIRS	37,760	225,033		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,957	4,824	41,426	8.00
9.00	00900	HOUSEKEEPING	15,107	4,476	0	9.00
10.00	01000	DIETARY	9,430	8,421	59	10.00
11.00	01100	CAFETERIA	9,950	2,345	288	11.00
13.00	01300	NURSING ADMINISTRATION	21,899	4,894	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,250	15,587	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,611	5,892	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	54,091	20,675	14,025	30.00
40.00	04000	SUBPROVIDER - I PF	29,573	11,167	5,562	40.00
43.00	04300	NURSERY	17,652	5,098	2,118	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	37,009	19,911	4,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,134	1,195	496	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,935	14,564	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	34,369	6,318	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	7,394	3,592	2,638	65.00
66.00	06600	PHYSICAL THERAPY	21,857	11,276	1,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,197	2,656	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,243	1,658	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,893	319	1,509	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,830	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,727	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,802	2,584	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	2,950	5,023	0	75.01
76.97	07697	CARDIAC REHABILITATION	185	986	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	96,463	46,789	343	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	27,040	5,685	5,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			1,317	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	20,717	5,300	1,146	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,025	211,235	40,213	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	20,671	12,419	1,184	192.00
193.00	19300	NONPAID WORKERS	485	1,379	0	193.00
194.00	07950	EMERALD POINT	12,507	0	29	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	608,688	225,033	41,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	29,063					11.00
13.00	01300	2,217	63,362				13.00
14.00	01400	600	0	132,562			14.00
16.00	01600	1,242	0	151	60,188		16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,447	26,516	3,136	2,810		30.00
40.00	04000	3,589	17,470	659	1,706		40.00
43.00	04300	981	4,777	649	256		43.00
44.00	04400	0	0	0	0		44.00
45.00	04500	0	0	0	0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,768	0	9,343	4,090		50.00
52.00	05200	230	0	152	452		52.00
53.00	05300	0	0	0	0		53.00
54.00	05400	2,112	0	9,426	17,443		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	0	0	0		59.00
60.00	06000	2,738	0	36,168	11,119		60.00
60.01	06001	0	0	0	0		60.01
65.00	06500	999	0	1,228	1,494		65.00
66.00	06600	0	0	785	4,156		66.00
67.00	06700	0	0	0	740		67.00
68.00	06800	0	0	0	240		68.00
69.00	06900	373	0	0	1,084		69.00
71.00	07100	0	0	42,435	1,146		71.00
72.00	07200	0	0	5,695	201		72.00
73.00	07300	1,207	0	0	5,478		73.00
75.00	07500	0	0	0	0		75.00
75.01	07501	308	1,499	19	116		75.01
76.97	07697	69	0	28	166		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	365	0	13,453	0		88.00
90.00	09000	0	0	0	0		90.00
91.00	09100	2,691	13,100	2,223	5,165		91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	3,029	2,326		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0		190.00
192.00	19200	627	0	686	0		192.00
193.00	19300	0	0	196	0		193.00
194.00	07950	500	0	3,101	0		194.00
194.01	07951	0	0	0	0		194.01
200.00							0200.00
201.00							0201.00
202.00		29,063	63,362	132,562	60,188		0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/30/2018 10:31 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
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
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	303,483	0	303,483	30.00
40.00	04000	158,195	0	158,195	40.00
43.00	04300	67,282	0	67,282	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	217,019	0	217,019	50.00
52.00	05200	15,038	0	15,038	52.00
53.00	05300	0	0	0	53.00
54.00	05400	182,579	0	182,579	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	135,085	0	135,085	60.00
60.01	06001	0	0	0	60.01
65.00	06500	42,536	0	42,536	65.00
66.00	06600	118,779	0	118,779	66.00
67.00	06700	27,181	0	27,181	67.00
68.00	06800	16,744	0	16,744	68.00
69.00	06900	8,430	0	8,430	69.00
71.00	07100	56,411	0	56,411	71.00
72.00	07200	7,623	0	7,623	72.00
73.00	07300	69,296	0	69,296	73.00
75.00	07500	0	0	0	75.00
75.01	07501	45,084	0	45,084	75.01
76.97	07697	8,333	0	8,333	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	484,924	0	484,924	88.00
90.00	09000	0	0	0	90.00
91.00	09100	101,788	0	101,788	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	69,763	0	69,763	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	0	113.00
118.00		2,135,573	0	2,135,573	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	122,547	0	122,547	192.00
193.00	19300	11,711	0	11,711	193.00
194.00	07950	124,527	0	124,527	194.00
194.01	07951	0	0	0	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,394,358	0	2,394,358	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	136,867				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		136,867			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	162	162	10,030,943		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	35,189	35,189	1,363,156	-4,731,676	5.00
6.00 00600	MAINTENANCE & REPAIRS	11,113	11,113	282,327	0	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,938	1,938	0	0	8.00
9.00 00900	HOUSEKEEPING	1,798	1,798	377,371	0	9.00
10.00 01000	DIETARY	3,383	3,383	381,248	0	10.00
11.00 01100	CAFETERIA	942	942	254,338	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,966	1,966	369,553	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,262	6,262	116,855	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,367	2,367	200,479	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	8,306	8,306	1,099,515	0	30.00
40.00 04000	SUBPROVIDER - IPF	4,486	4,486	809,706	0	40.00
43.00 04300	NURSERY	2,048	2,048	264,110	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	7,999	7,999	686,558	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	480	480	61,848	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,851	5,851	608,856	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	2,538	2,538	579,702	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,443	1,443	192,088	0	65.00
66.00 06600	PHYSICAL THERAPY	4,530	4,530	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,067	1,067	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	666	666	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	128	128	77,732	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	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	1,038	1,038	522,375	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	2,018	2,018	45,723	0	75.01
76.97 07697	CARDIAC REHABILITATION	396	396	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	18,797	18,797	157,897	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	2,284	2,284	763,579	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	2,129	2,129	567,864	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	131,324	131,324	9,782,880	-4,731,676	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	4,989	4,989	161,841	0	192.00
193.00 19300	NONPAID WORKERS	554	554	0	0	193.00
194.00 07950	EMERALD POINT	0	0	86,222	0	194.00
194.01 07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,244,121	1,061,372	2,459,872	4,731,676	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.090000	7.754769	0.245228	0.205371	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			2,729	608,688	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000272	0.026419	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
207.00   NAHE unit cost multiplier (Wkst. D, Parts III and IV)			4.00	5A	5.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		6.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	90,403					6.00
8.00	00800	1,938	111,935				8.00
9.00	00900	1,798	0	86,667			9.00
10.00	01000	3,383	160	3,383	34,710		10.00
11.00	01100	942	777	942	0	255,739	11.00
13.00	01300	1,966	0	1,966	0	19,506	13.00
14.00	01400	6,262	0	6,262	0	5,276	14.00
16.00	01600	2,367	0	2,367	0	10,932	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	8,306	37,898	8,306	14,336	47,928	30.00
40.00	04000	4,486	15,028	4,486	4,554	31,579	40.00
43.00	04300	2,048	5,722	2,048	0	8,635	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	7,999	11,775	7,999	0	24,358	50.00
52.00	05200	480	1,339	480	0	2,022	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	5,851	0	5,851	0	18,582	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,538	0	2,538	0	24,093	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,443	7,129	1,443	0	8,794	65.00
66.00	06600	4,530	4,827	4,530	0	0	66.00
67.00	06700	1,067	0	1,067	0	0	67.00
68.00	06800	666	0	666	0	0	68.00
69.00	06900	128	4,078	128	0	3,284	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,038	0	1,038	0	10,618	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	2,018	0	2,018	0	2,709	75.01
76.97	07697	396	0	396	0	606	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	18,797	927	18,797	0	3,216	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,284	15,901	2,284	0	23,680	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	2,129	3,097	2,129	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		84,860	108,658	81,124	18,890	245,818	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	4,989	3,199	4,989	0	5,518	192.00
193.00	19300	554	0	554	0	0	193.00
194.00	07950	0	78	0	15,820	4,403	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,722,786	217,477	723,540	523,266	481,295	202.00
203.00		19.056735	1.942886	8.348506	15.075367	1.881977	203.00
204.00		225,033	41,426	49,973	76,950	29,063	204.00
205.00		2.489220	0.370090	0.576609	2.216940	0.113643	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

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

Worksheet B-1

Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	16.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	114,531				13.00
14.00	01400	0	1,521,381			14.00
16.00	01600	0	1,738	61,810,731		16.00
19.00	01900	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	47,928	35,989	2,885,044	0	30.00
40.00	04000	31,579	7,560	1,751,418	0	40.00
43.00	04300	8,635	7,445	262,692	0	43.00
44.00	04400	0	0	0	0	44.00
45.00	04500	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	107,225	4,198,936	0	50.00
52.00	05200	0	1,744	463,631	0	52.00
53.00	05300	0	0	0	0	53.00
54.00	05400	0	108,178	17,926,556	0	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	415,090	11,415,944	0	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	0	14,099	1,533,486	0	65.00
66.00	06600	0	9,004	4,266,696	0	66.00
67.00	06700	0	0	760,078	0	67.00
68.00	06800	0	0	246,535	0	68.00
69.00	06900	0	0	1,112,803	0	69.00
71.00	07100	0	487,029	1,176,109	0	71.00
72.00	07200	0	65,363	206,336	0	72.00
73.00	07300	0	0	5,623,839	0	73.00
75.00	07500	0	0	0	0	75.00
75.01	07501	2,709	217	119,258	0	75.01
76.97	07697	0	318	170,102	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	154,395	0	0	88.00
90.00	09000	0	0	0	0	90.00
91.00	09100	23,680	25,515	5,302,913	0	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	34,759	2,388,355	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
118.00	11800	114,531	1,475,668	61,810,731	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	7,874	0	0	192.00
193.00	19300	0	2,251	0	0	193.00
194.00	07950	0	35,588	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00						201.00
202.00		1,089,713	512,342	615,766	0	202.00
203.00		9.514568	0.336761	0.009962	0.000000	203.00
204.00		63,362	132,562	60,188	0	204.00
205.00		0.553230	0.087133	0.000974	0.000000	205.00
206.00						206.00
207.00						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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		3,572,359	0	3,572,359	30.00
40.00	04000 SUBPROVIDER - IPF		1,949,972	6	1,949,978	40.00
43.00	04300 NURSERY		976,131	0	976,131	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,054,415	0	2,054,415	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		213,370	0	213,370	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,095,490	0	2,095,490	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,936,521	0	1,936,521	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	427,326	0	427,326	65.00
66.00	06600 PHYSICAL THERAPY	0	1,176,303	0	1,176,303	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	273,948	0	273,948	67.00
68.00	06800 SPEECH PATHOLOGY	0	168,672	0	168,672	68.00
69.00	06900 ELECTROCARDIOLOGY		160,684	0	160,684	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		761,092	0	761,092	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		102,855	0	102,855	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,011,685	0	2,011,685	73.00
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS		222,012	0	222,012	75.01
76.97	07697 CARDIAC REHABILITATION		22,240	0	22,240	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		4,975,924	0	4,975,924	88.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		1,658,502	0	1,658,502	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		340,869	0	340,869	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		1,045,082	0	1,045,082	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		26,145,452	6	26,145,458	200.00
201.00	Less Observation Beds		340,869		340,869	201.00
202.00	Total (see instructions)		25,804,583	6	25,804,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 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	2,743,171		2,743,171		30.00
40.00	04000	SUBPROVIDER - I/PF	1,665,291		1,665,291		40.00
43.00	04300	NURSERY	249,774		249,774		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	406,417	3,792,519	4,198,936	0.489270	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	320,155	143,476	463,631	0.460215	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,873	17,195,683	17,926,556	0.116893	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,856,340	9,559,604	11,415,944	0.169633	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	534,035	999,451	1,533,486	0.278663	65.00
66.00	06600	PHYSICAL THERAPY	505,606	3,761,090	4,266,696	0.275694	66.00
67.00	06700	OCCUPATIONAL THERAPY	276,915	483,163	760,078	0.360421	67.00
68.00	06800	SPEECH PATHOLOGY	152,199	94,336	246,535	0.684171	68.00
69.00	06900	ELECTROCARDIOLOGY	94,729	1,018,074	1,112,803	0.144396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	345,876	830,233	1,176,109	0.647127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	922	205,414	206,336	0.498483	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,340,867	4,282,972	5,623,839	0.357707	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	418	118,840	119,258	1.861611	75.01
76.97	07697	CARDIAC REHABILITATION	0	170,102	170,102	0.130745	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,480,680	2,480,680		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	524,390	4,778,523	5,302,913	0.312753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	66,359	174,558	240,917	1.414881	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	208,331	2,180,024	2,388,355	0.437574	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	12,022,668	52,268,742	64,291,410		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,022,668	52,268,742	64,291,410		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/30/2018 10:31 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.489270		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.460215		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116893		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.169633		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.278663		65.00
66.00	06600 PHYSICAL THERAPY	0.275694		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.360421		67.00
68.00	06800 SPEECH PATHOLOGY	0.684171		68.00
69.00	06900 ELECTROCARDIOLOGY	0.144396		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.647127		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.498483		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357707		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.861611		75.01
76.97	07697 CARDIAC REHABILITATION	0.130745		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.312753		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.414881		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.437574		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/30/2018 10:31 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)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	303,483	2,215	301,268	2,268	132.83	30.00
40.00	SUBPROVIDER - IPF	158,195	0	158,195	1,518	104.21	40.00
43.00	NURSERY	67,282		67,282	311	216.34	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	528,960		526,745	4,097		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	834	110,780				
40.00	SUBPROVIDER - IPF	1,154	120,258				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	1,988	231,038				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/30/2018 10:31 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	217,019	4,198,936	0.051684	56,794	2,935	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15,038	463,631	0.032435	4,353	141	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	182,579	17,926,556	0.010185	593,239	6,042	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	135,085	11,415,944	0.011833	829,211	9,812	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	42,536	1,533,486	0.027738	313,815	8,705	65.00
66.00	06600 PHYSICAL THERAPY	118,779	4,266,696	0.027839	104,876	2,920	66.00
67.00	06700 OCCUPATIONAL THERAPY	27,181	760,078	0.035761	12,752	456	67.00
68.00	06800 SPEECH PATHOLOGY	16,744	246,535	0.067917	26,571	1,805	68.00
69.00	06900 ELECTROCARDIOLOGY	8,430	1,112,803	0.007575	70,286	532	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	56,411	1,176,109	0.047964	129,599	6,216	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,623	206,336	0.036945	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,296	5,623,839	0.012322	409,544	5,046	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	45,084	119,258	0.378038	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	8,333	170,102	0.048988	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	484,924	2,480,680	0.195480	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	101,788	5,302,913	0.019195	433,070	8,313	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	28,958	240,917	0.120199	25,896	3,113	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,565,808	57,244,819		3,010,006	56,036	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/30/2018 10:31 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	0	0	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	2,268	0.00	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	1,518	0.00	40.00	
43.00	04300	NURSERY	0	0	311	0.00	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0.00	45.00	
200.00		Total (lines 30 through 199)	0	0	4,097	1,988	200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
45.00	04500	NURSING FACILITY	0					45.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/30/2018 10:31 am

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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 10:31 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	4,198,936	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	463,631	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,926,556	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	11,415,944	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,533,486	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,266,696	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	760,078	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	246,535	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,112,803	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,176,109	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	206,336	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,623,839	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	119,258	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	170,102	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,480,680	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,302,913	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	240,917	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	57,244,819		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/30/2018 10:31 am

Cost Center Description		Title XVIII			Hospital		PPS
		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	0.000000	56,794	0	1,310,312	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	4,353	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	593,239	0	6,019,080	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	829,211	0	1,386,781	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	313,815	0	386,560	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	104,876	0	12,254	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	12,752	0	1,005	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	26,571	0	1,270	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	70,286	0	409,032	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	129,599	0	204,939	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	76,440	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	409,544	0	1,937,968	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	99,158	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	82,790	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	433,070	0	1,381,971	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	25,896	0	93,754	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		3,010,006	0	13,403,314	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/30/2018 10:31 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	0.489270	1,310,312	0	0	641,096	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.460215	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116893	6,019,080	0	0	703,588	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.169633	1,386,781	0	0	235,244	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.278663	386,560	0	0	107,720	65.00
66.00	06600	PHYSICAL THERAPY	0.275694	12,254	0	0	3,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.360421	1,005	0	0	362	67.00
68.00	06800	SPEECH PATHOLOGY	0.684171	1,270	0	0	869	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144396	409,032	0	0	59,063	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.647127	204,939	0	0	132,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498483	76,440	0	0	38,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357707	1,937,968	0	14,540	693,225	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1.861611	99,158	0	0	184,594	75.01
76.97	07697	CARDIAC REHABILITATION	0.130745	82,790	0	0	10,824	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.312753	1,381,971	0	0	432,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.414881	93,754	0	0	132,651	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.437574	0	0	0	0	95.00
200.00		Subtotal (see instructions)		13,403,314	0	14,540	3,375,556	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		13,403,314	0	14,540	3,375,556	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/30/2018 10:31 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
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,201	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	5,201	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	5,201	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/30/2018 10:31 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	217,019	4,198,936	0.051684	78	4	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15,038	463,631	0.032435	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	182,579	17,926,556	0.010185	51,900	529	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	135,085	11,415,944	0.011833	258,648	3,061	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	42,536	1,533,486	0.027738	3,026	84	65.00
66.00	06600 PHYSICAL THERAPY	118,779	4,266,696	0.027839	59,484	1,656	66.00
67.00	06700 OCCUPATIONAL THERAPY	27,181	760,078	0.035761	7,680	275	67.00
68.00	06800 SPEECH PATHOLOGY	16,744	246,535	0.067917	4,756	323	68.00
69.00	06900 ELECTROCARDIOLOGY	8,430	1,112,803	0.007575	19,697	149	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	56,411	1,176,109	0.047964	3,697	177	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,623	206,336	0.036945	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,296	5,623,839	0.012322	262,351	3,233	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	45,084	119,258	0.378038	418	158	75.01
76.97	07697 CARDIAC REHABILITATION	8,333	170,102	0.048988	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	484,924	2,480,680	0.195480	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	101,788	5,302,913	0.019195	50,300	966	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	240,917	0.000000	1,810	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,536,850	57,244,819		723,845	10,615	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 10:31 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	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<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
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 10:31 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	4,198,936	0.000000 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	463,631	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,926,556	0.000000 54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000 57.00
58.00	05800	MRI	0	0	0	0	0.000000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000 59.00
60.00	06000	LABORATORY	0	0	0	11,415,944	0.000000 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,533,486	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,266,696	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	760,078	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	246,535	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,112,803	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,176,109	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	206,336	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,623,839	0.000000 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000 75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	119,258	0.000000 75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	170,102	0.000000 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,480,680	0.000000 88.00
90.00	09000	CLINIC	0	0	0	0	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	5,302,913	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	240,917	0.000000 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	57,244,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 10:31 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	78	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	51,900	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	258,648	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.000000	3,026	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	59,484	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	7,680	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	4,756	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	19,697	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	3,697	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	0.000000	262,351	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0.000000	418	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	50,300	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	1,810	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		723,845	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/30/2018 10:31 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)		3,482	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,268	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)		2,050	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		522	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)		522	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		85	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)		85	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		834	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)		373	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)		380	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		153.39	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		153.39	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,572,359	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)		13,038	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)		13,038	25.00
26.00	Total swing-bed cost (see instructions)		26,076	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,546,283	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)		3,546,283	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)		1,563.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,304,059	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)		1,304,059	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1	
Date/Time Prepared: 11/30/2018 10:31 am		Title XVIII		Hospital		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)	0	0	0.00	0			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)					791,533		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,095,592		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)					110,780		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					56,036		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					166,816		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,928,776		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)					218		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,563.62		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					340,869		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/30/2018 10:31 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	303,483	3,572,359	0.084953	340,869	28,958	90.00
91.00	Nursing School cost	0	3,572,359	0.000000	340,869	0	91.00
92.00	Allied health cost	0	3,572,359	0.000000	340,869	0	92.00
93.00	All other Medical Education	0	3,572,359	0.000000	340,869	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/30/2018 10:31 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)		1,518	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,518	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,518	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)		1,154	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)		1,949,978	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)		1,949,978	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)		1,949,978	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)		1,284.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,482,394	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)		1,482,394	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1
				Component CCN: 14-S137		Date/Time Prepared: 11/30/2018 10:31 am
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	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)					191,395	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,673,789	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)					120,258	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,615	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					130,873	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,542,916	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137 Component CCN: 14-S137		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/30/2018 10:31 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	158,195	1,949,978	0.081127	0	0	90.00
91.00	Nursing School cost	0	1,949,978	0.000000	0	0	91.00
92.00	Allied health cost	0	1,949,978	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,949,978	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/30/2018 10:31 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		815,089		30.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.489270	56,794	27,788	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.460215	4,353	2,003	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116893	593,239	69,345	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.169633	829,211	140,662	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.278663	313,815	87,449	65.00
66.00	06600 PHYSICAL THERAPY	0.275694	104,876	28,914	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.360421	12,752	4,596	67.00
68.00	06800 SPEECH PATHOLOGY	0.684171	26,571	18,179	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144396	70,286	10,149	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.647127	129,599	83,867	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.498483	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357707	409,544	146,497	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.861611	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.130745	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.312753	433,070	135,444	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.414881	25,896	36,640	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,010,006	791,533	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)		3,010,006		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/30/2018 10:31 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
40.00	04000 SUBPROVIDER - IPF		1,137,782	40.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.489270	78	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.460215	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116893	51,900	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.169633	258,648	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.278663	3,026	65.00
66.00	06600 PHYSICAL THERAPY	0.275694	59,484	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.360421	7,680	67.00
68.00	06800 SPEECH PATHOLOGY	0.684171	4,756	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144396	19,697	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.647127	3,697	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.498483	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357707	262,351	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.861611	418	75.01
76.97	07697 CARDIAC REHABILITATION	0.130745	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.312753	50,300	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.414881	1,810	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		723,845	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)		723,845	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0137 Component CCN: 14-U137	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/30/2018 10:31 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.489270	311	152	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.460215	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116893	49,270	5,759	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.169633	148,777	25,237	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.278663	97,427	27,149	65.00
66.00	06600 PHYSICAL THERAPY	0.275694	185,798	51,223	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.360421	162,205	58,462	67.00
68.00	06800 SPEECH PATHOLOGY	0.684171	68,488	46,858	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144396	4,694	678	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.647127	32,481	21,019	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.498483	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357707	167,441	59,895	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	1.861611	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.130745	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.312753	965	302	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.414881	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		917,857	296,734	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)		917,857		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/30/2018 10:31 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)		448,837	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,346,511	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)		0	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		16,240	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		28.08	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)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which 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)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	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)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	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.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	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		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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)		0.00	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)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)		38.85	31.00
32.00	Sum of lines 30 and 31		44.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		53,860	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/30/2018 10:31 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	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	175,086	210,989	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	44,131	157,808	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	201,939		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)	2,051,147		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		2,051,147	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		144,881	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).		0	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).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		2,196,028	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,196,028	61.00
62.00	Deductibles billed to program beneficiaries		256,052	62.00
63.00	Coinurance billed to program beneficiaries		5,695	63.00
64.00	Allowable bad debts (see instructions)		106,248	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		69,061	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		106,248	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,003,342	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)		17,454	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/30/2018 10:31 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
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)	2017	111,325	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)	2018	376,237	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		6,178	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,502,180	71.00
71.01	Sequestration adjustment (see instructions)		50,044	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		2,417,722	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)		34,414	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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 (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	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0137

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/30/2018 10:31 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	448,837	0	448,837		448,837	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,346,511	0		1,346,511	1,346,511	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	16,240	0	8,120	8,120	16,240	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	53,860	0	13,465	40,395	53,860	11.00
11.01	Uncompensated care payments	36.00	201,939	0	44,131	157,808	201,939	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,051,147	0	506,433	1,544,714	2,051,147	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,051,147	0	506,433	1,544,714	2,051,147	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	144,881	0	0	144,881	144,881	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0137

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/30/2018 10:31 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	506,433	1,689,595	2,196,028	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	144,881	0	0	144,881	144,881	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	144,881	0	0	144,881	144,881	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.219821	0.222679		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			111,325		111,325	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				376,237	376,237	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2018 10:31 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	448,837	448,837		448,837	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,346,511		1,346,511	1,346,511	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	16,240	8,120	8,120	16,240	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	53,860	13,465	40,395	53,860	11.00
11.01	Uncompensated care payments	36.00	201,939	44,131	157,808	201,939	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,051,147	506,433	1,544,714	2,051,147	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,051,147	506,433	1,544,714	2,051,147	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	144,881	0	144,881	144,881	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			506,433	1,689,595	2,196,028	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2018 10:31 am
Title XVIII			Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	144,881	0	144,881	144,881	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	144,881	0	144,881	144,881	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	111,325	111,325		111,325	28.00
29.00	Low volume adjustment on or after October 1	70.97	376,237		376,237	376,237	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	17,454	0	17,454	17,454	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		6,178	0	6,178	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/30/2018 10:31 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		5,201	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,375,556	2.00
3.00	OPPS payments		2,332,227	3.00
4.00	Outlier payment (see instructions)		2,223	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,201	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		14,540	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)		14,540	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)		14,540	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,339	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,201	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)		2,334,450	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		469,749	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)		1,869,902	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)		1,869,902	30.00
31.00	Primary payer payments		110	31.00
32.00	Subtotal (line 30 minus line 31)		1,869,792	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)		57,476	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		37,359	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		57,476	36.00
37.00	Subtotal (see instructions)		1,907,151	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,907,151	40.00
40.01	Sequestration adjustment (see instructions)		38,143	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,890,036	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-21,028	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0137		Period: From 07/01/2017 To 06/30/2018		Worksheet E-1 Part I Date/Time Prepared: 11/30/2018 10:31 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		2,417,722		1,890,036	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)		2,417,722		1,890,036	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		34,414		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		21,028	6.02	
7.00	Total Medicare program liability (see instructions)		2,452,136		1,869,008	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: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part I Date/Time Prepared: 11/30/2018 10:31 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		934,131		0
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
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)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		934,131		0
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)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		934,131		0
			0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00
8.00	Name of Contractor				0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0137  
Component CCN: 14-U137

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/30/2018 10:31 am

Title XVIII Swing Beds - SNF 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		316,912		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		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)		316,912		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		316,912		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/30/2018 10:31 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2
		Component CCN: 14-U137		Date/Time Prepared: 11/30/2018 10:31 am
		Title XVIII	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	351,124	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	753	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	351,124	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	351,124	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	351,124	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	27,744	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	323,380	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	323,380	0	19.00
19.01	Sequestration adjustment (see instructions)	6,468	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	316,912	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
<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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
<b>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement</b>				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/30/2018 10:31 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)			1,048,250 1.00
2.00	Net IPF PPS Outlier Payments			7,093 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)			4.158904 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)			1,055,343 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)			1,055,343 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,055,343 18.00
19.00	Deductibles			102,148 19.00
20.00	Subtotal (line 18 minus line 19)			953,195 20.00
21.00	Coinurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			953,195 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			953,195 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			953,195 31.00
31.01	Sequestration adjustment (see instructions)			19,064 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			934,131 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)			0 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			7,093 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0137

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

Worksheet G

Date/Time Prepared:  
11/30/2018 10:31 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	2,540,146	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,878,956	0	0	0	4.00
5.00	Other receivable	194,886	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,008,092	0	0	0	6.00
7.00	Inventory	441,170	0	0	0	7.00
8.00	Prepaid expenses	139,106	0	0	0	8.00
9.00	Other current assets	653,000	0	0	0	9.00
10.00	Due from other funds	54,921	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,894,093	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,540,441	0	0	0	12.00
13.00	Land improvements	406,675	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	6,528,979	0	0	0	15.00
16.00	Accumulated depreciation	-1,334,383	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	2,152,377	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	1,341,524	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,635,613	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	624,922	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	624,922	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,154,628	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,810,242	0	0	0	37.00
38.00	Salaries, wages, and fees payable	917,226	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	676,234	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	579,569	0	0	0	43.00
44.00	Other current liabilities	1,152,039	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,135,310	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,071,242	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,171,022	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,242,264	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,377,574	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-3,222,946	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-3,222,946	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,154,628	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0137

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

Worksheet G-1

Date/Time Prepared:  
11/30/2018 10:31 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		1,534,265		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,666,047				2.00
3.00	Total (sum of line 1 and line 2)		-3,131,782		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,131,782		0		11.00
12.00	NET TRANSFERS	91,164		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		91,164		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,222,946		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	NET TRANSFERS		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: 14-0137

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/30/2018 10:31 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	2,444,933		2,444,933	1.00
2.00	SUBPROVIDER - IPF	1,665,291		1,665,291	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	479,250		479,250	5.00
6.00	Swing bed - NF	78,039		78,039	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,667,513		4,667,513	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,667,513		4,667,513	17.00
18.00	Ancillary services	6,592,040	43,328,729	49,920,769	18.00
19.00	Outpatient services	594,899	4,992,734	5,587,633	19.00
20.00	RURAL HEALTH CLINIC	0	2,480,680	2,480,680	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	208,331	2,185,782	2,394,113	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL SERVICES	277,988	1,062,853	1,340,841	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,340,771	54,050,778	66,391,549	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,584,888		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)		31,584,888		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0137

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

Worksheet G-3

Date/Time Prepared:  
11/30/2018 10:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,391,549	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,794,788	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,596,761	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,584,888	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,988,127	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	5,181	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	123,085	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	1,401	16.00
17.00	Revenue from sale of drugs to other than patients	23,140	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	984	21.00
22.00	Rental of hospital space	407,098	22.00
23.00	Governmental appropriations	43,910	23.00
24.00	MISC REVENUE	342,415	24.00
24.01	AUX REVENUE	371,906	24.01
24.02	INVESTMENT INCOME	7,065	24.02
25.00	Total other income (sum of lines 6-24)	1,326,185	25.00
26.00	Total (line 5 plus line 25)	-4,661,942	26.00
27.00	GAIN/LOSS DISPOSAL FIXED ASSETS	4,105	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,105	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,666,047	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0137	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/30/2018 10:31 am
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		144,881	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	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)		5.83	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	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)		144,881	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: 14-0137

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-8519

To 06/30/2018

Date/Time Prepared: 11/30/2018 10:31 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	0	971,468	971,468	0	971,468	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	770,330	770,330	0	770,330	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	569,244	569,244	0	569,244	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,311,042	2,311,042	0	2,311,042	10.00
11.00	Physician Services Under Agreement	0	12,581	12,581	0	12,581	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,581	12,581	0	12,581	14.00
15.00	Medical Supplies	0	129,757	129,757	0	129,757	15.00
16.00	Transportation (Health Care Staff)	0	1,055	1,055	0	1,055	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	5,556	5,556	0	5,556	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	136,368	136,368	0	136,368	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,459,991	2,459,991	0	2,459,991	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	8,907	8,907	0	8,907	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	8,907	8,907	0	8,907	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	4,296	4,296	0	4,296	29.00
30.00	Administrative Costs	157,897	266,474	424,371	0	424,371	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	157,897	270,770	428,667	0	428,667	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	157,897	2,739,668	2,897,565	0	2,897,565	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0137  
Component CCN: 14-8519

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

Worksheet M-1  
Date/Time Prepared:  
11/30/2018 10:31 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
<b>FACILITY HEALTH CARE STAFF COSTS</b>					
1.00	Physician	0	971,468		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	770,330		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	569,244		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,311,042		10.00
11.00	Physician Services Under Agreement	0	12,581		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,581		14.00
15.00	Medical Supplies	0	129,757		15.00
16.00	Transportation (Health Care Staff)	0	1,055		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	5,556		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	136,368		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,459,991		22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>					
23.00	Pharmacy	0	8,907		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	8,907		28.00
<b>FACILITY OVERHEAD</b>					
29.00	Facility Costs	0	4,296		29.00
30.00	Administrative Costs	398,187	822,558		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	398,187	826,854		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	398,187	3,295,752		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0137 Component CCN: 14-8519	Period: From 07/01/2017 To 06/30/2018	Worksheet M-2 Date/Time Prepared: 11/30/2018 10:31 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	2.80	5,971	4,200	11,760	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	4.78	10,087	2,100	10,038	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.58	16,058		21,798	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.58	16,058		21,798	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)				2,459,991	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				8,907	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,468,898	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.996392	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				826,854	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,680,172	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,507,026	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,507,026	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,497,981	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,957,972	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0137 Component CCN: 14-8519	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/30/2018 10:31 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)			4,957,972	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			43,927	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,914,045	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,798	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)			21,798	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			225.44	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)	225.44	225.44		9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)	2,327	2,328		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	524,599	524,824		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,049,423		16.00
16.01	Total program charges (see instructions)(from contractor's records)		685,414		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,843		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,822		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.)		770,816		16.04
16.05	Total program cost (see instructions)	0	773,638		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		83,081		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		120,098		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		773,638		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,702		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		791,340		22.00
23.00	Allowable bad debts (see instructions)		29,107		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		18,920		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,107		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)		810,260		26.00
26.01	Sequestration adjustment (see instructions)		16,205		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		895,192		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)		-101,137		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: 14-0137 Component CCN: 14-8519	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/30/2018 10:31 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)	2,311,042	2,311,042	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000216	0.000858	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	499	1,983	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,221	7,092	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	12,720	9,075	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,459,991	2,459,991	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,497,981	2,497,981	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005171	0.003689	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,917	9,215	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	25,637	18,290	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	110	438	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	233.06	41.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	48	156	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,187	6,515	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)		43,927	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)		17,702	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0137 Component CCN: 14-8519	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/30/2018 10:31 am
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		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		895,192	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)		895,192	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		101,137	6.02
7.00	Total Medicare program liability (see instructions)		794,055	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00