

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: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 4:14 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/27/2019 Time: 4:14 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF HOLY FAMILY MED CTR (14-1318) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	150,214	-209,140	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	151,424	0			0 5.00
6.00 Swing bed - NF	0					0 6.00
10.00 RURAL HEALTH CLINIC I	0		67,414			0 10.00
200.00 Total	0	301,638	-141,726	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:14 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1000 WEST HARLEM AVENUE		PO Box:						1.00		
2.00	City: MONMOUTH		State: IL		Zip Code: 61462		County: WARREN		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
							V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		OSF HOLY FAMILY MED CTR	141318	99914	1	05/01/2002	N	O	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		OSF HOLY FAMILY SWING BEDS	14Z318	99914		05/01/2002	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		OSF HOLY FAMILY CLINICS	143461	99914		02/05/2003	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)					10/01/2017	09/30/2018		20.00		
21.00	Type of Control (see instructions)					1			21.00		
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		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				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:14 pm			
		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	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00	

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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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0 71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
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			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:14 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	253,839	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
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		149006		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:14 pm	
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: OSF HEALTHCARE SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 800 N. E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
144.00 Are provider based physicians' costs included in Worksheet A?							
						1.00	144.00
						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.							
						1.00	145.00
						N	
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.							
						1.00	146.00
						N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
						1.00	147.00
						N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
						1.00	148.00
						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
						1.00	149.00
						N	
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
						1.00	165.00
						N	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
166.00							
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							
						1.00	167.00
						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)							
						1.00	168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							
						1.00	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)							
						1.00	169.00
						0.00	
				Beginning	Ending		
				1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
				10/01/2017	09/30/2018		
170.00							
						1.00	
						2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							
						1.00	171.00
						N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 4:14 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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)	N					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		01/21/2019		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/18/2018	Y	12/18/2018		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: 14-1318

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

Worksheet S-2
Part II
Date/Time Prepared:
2/27/2019 4:14 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
					1.00	2.00
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REBECCA C		ROBINSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)624-7644		REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 4:14 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVERNMENT REPORTING SENIOR ANALYST		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: 14-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	23	8,395	14,304.00	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)		23	8,395	14,304.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		23	8,395	14,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		23				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: 14-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	374	90	596			1.00
2.00 HMO and other (see instructions)	82	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	581	0	772			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	92			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	955	90	1,460			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)	955	90	1,460	0.00	98.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	6,402	0	31,709	0.00	10.64	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	108.64	27.00
28.00 Observation Bed Days		27	201			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	138	27	212	1.00
2.00	HMO and other (see instructions)			28	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	138	27	212	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/27/2019 4:14 pm	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		1000 W. HARLEM		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		MONMOUTH ILLINOIS		61462 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	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	11.00	Facility hours of operations (1) CLINIC		07:00 20:00		07:00	
				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.		N		0	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number					
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					
				County			
				4.00			
2.00	2.00	City, State, ZIP Code, County		WARREN			
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	11.00	Facility hours of operations (1) CLINIC		20:00 07:00		20:00 07:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/27/2019 4:14 pm	
				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	20:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/27/2019 4:14 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.370848	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,506,251	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?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		14,768,601	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,476,906	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)		970,655	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		970,655	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,679,281	413,047	2,092,328	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	622,758	413,047	1,035,805	21.00
22.00	Payments received from patients for amounts previously written off as charity care	11,588	0	11,588	22.00
23.00	Cost of charity care (line 21 minus line 22)	611,170	413,047	1,024,217	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)			1,435,129	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			217,213	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			334,174	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,100,955	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			525,248	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,549,465	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,520,120	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

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

Worksheet A
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		623,106	623,106	393,199	1,016,305	1.00
2.00	00200		405,135	405,135	569,012	974,147	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	2,306,445	2,306,445	1,582,008	3,888,453	4.00
5.00	00500	1,327,871	5,351,747	6,679,618	-1,113,082	5,566,536	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	353,792	964,317	1,318,109	-259,886	1,058,223	7.00
8.00	00800	0	0	0	95,503	95,503	8.00
9.00	00900	318,211	106,033	424,244	-97,351	326,893	9.00
10.00	01000	271,429	134,002	405,431	-10,551	394,880	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	220,610	2,630	223,240	0	223,240	16.00
17.00	01700	145,118	7,522	152,640	200,584	353,224	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,008,117	100,943	1,109,060	-80,641	1,028,419	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	423,286	359,175	782,461	-180,882	601,579	50.00
53.00	05300	203,669	57,139	260,808	-5,498	255,310	53.00
54.00	05400	578,203	223,024	801,227	118,734	919,961	54.00
56.00	05600	32,518	37,695	70,213	-2,752	67,461	56.00
57.00	05700	0	62,945	62,945	-45,496	17,449	57.00
58.00	05800	0	245,701	245,701	-2,176	243,525	58.00
60.00	06000	513,393	500,241	1,013,634	12,659	1,026,293	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	141,858	13,024	154,882	-9,220	145,662	65.00
66.00	06600	336,536	3,053	339,589	16,744	356,333	66.00
67.00	06700	90,111	1,130	91,241	4,727	95,968	67.00
68.00	06800	12,670	206	12,876	799	13,675	68.00
69.00	06900	189,422	17,203	206,625	-13,569	193,056	69.00
71.00	07100	0	-21,795	-21,795	236,699	214,904	71.00
72.00	07200	0	0	0	27,422	27,422	72.00
73.00	07300	211,612	1,622,976	1,834,588	205,362	2,039,950	73.00
76.00	03950	73,791	8,036	81,827	-282	81,545	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,332,925	2,370,696	5,703,621	-1,123,024	4,580,597	88.00
91.00	09100	902,837	2,479,470	3,382,307	-519,042	2,863,265	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		10,687,979	17,981,799	28,669,778	0	28,669,778	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00		10,687,979	17,981,799	28,669,778	0	28,669,778	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

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

Worksheet A
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	242,728	1,259,033	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	183,627	1,157,774	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-311,723	3,576,730	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-492,390	5,074,146	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,058,223	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,503	8.00
9.00	00900	HOUSEKEEPING	0	326,893	9.00
10.00	01000	DIETARY	-54,154	340,726	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,295	218,945	16.00
17.00	01700	SOCIAL SERVICE	-39,919	313,305	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,028,419	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	601,579	50.00
53.00	05300	ANESTHESIOLOGY	-203,669	51,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,038	915,923	54.00
56.00	05600	RADIOISOTOPE	0	67,461	56.00
57.00	05700	CT SCAN	0	17,449	57.00
58.00	05800	MRI	0	243,525	58.00
60.00	06000	LABORATORY	-15,600	1,010,693	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	145,662	65.00
66.00	06600	PHYSICAL THERAPY	-135	356,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,968	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,675	68.00
69.00	06900	ELECTROCARDIOLOGY	0	193,056	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	214,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-569,587	1,470,363	73.00
76.00	03950	DIABETIC SERVICES	-1,628	79,917	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8	4,580,605	88.00
91.00	09100	EMERGENCY	-1,419,971	1,443,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,690,746	25,979,032	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,690,746	25,979,032	200.00

RECLASSIFICATIONS

Provider CCN: 14-1318

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

Worksheet A-6

Date/Time Prepared:
2/27/2019 4:14 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - MAINTENANCE COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	238,179	1.00
2.00	LABORATORY	60.00	0	50,977	2.00
	TOTALS		0	289,156	
B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	242,656	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	189,372	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	432,028	
F - PROPERTY INSURANCE					
1.00		0.00	0	0	1.00
9.00	OTHER CAP REL COSTS	3.00	0	18,606	9.00
	0		0	18,606	
G - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,160,045	1.00
2.00		0.00	0	0	2.00
6.00		0.00	0	0	6.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	0		0	1,160,045	
I - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	380,534	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	563,071	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	943,605	
J - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	31,356	64,147	1.00
	0		31,356	64,147	
K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	27,422	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
	0		0	27,422	
L - CLINIC A&G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,095	1.00
	0		0	20,095	
M - MINISTRY ALLOCATION RECLASS					
1.00	OPERATION OF PLANT	7.00	0	63,921	1.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	34,407	3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	421,963	4.00
5.00	PHYSICAL THERAPY	66.00	0	21,085	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	5,665	6.00
7.00	SPEECH PATHOLOGY	68.00	0	799	7.00

Provider CCN: 14-1318

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

Worksheet A-6
Date/Time Prepared:
2/27/2019 4:14 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
8.00	SOCIAL SERVICE	17.00	0	200,584	8.00	
	TOTALS		0	748,424		
500.00	Grand Total: Increases		31,356	3,703,528	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1318

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

Worksheet A-6
Date/Time Prepared:
2/27/2019 4:14 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - MAINTENANCE COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	289,156	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	289,156			
B - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	21,544	0		1.00
2.00	OPERATING ROOM	50.00	0	70,907	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	4,347	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,503	0		4.00
5.00	RADIOISOTOPE	56.00	0	596	0		5.00
6.00	CT SCAN	57.00	0	26,496	0		6.00
7.00	MRI	58.00	0	2,176	0		7.00
8.00	LABORATORY	60.00	0	14,756	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	7,225	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	3,270	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	938	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	943	0		12.00
13.00	DIABETIC SERVICES	76.00	0	282	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	203,931	0		14.00
15.00	EMERGENCY	91.00	0	56,114	0		15.00
	O		0	432,028			
F - PROPERTY INSURANCE							
1.00		0.00	0	0	0		1.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	18,606	0		9.00
	O		0	18,606			
G - EMPLOYEE BENEFIT RECLASS							
1.00		0.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,500	0		2.00
6.00	ADULTS & PEDIATRICS	30.00	0	11,079	0		6.00
11.00	RURAL HEALTH CLINIC	88.00	0	711,890	0		11.00
12.00	EMERGENCY	91.00	0	433,576	0		12.00
	O		0	1,160,045			
I - DEPRECIATION RECLASS							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	73,491	9		2.00
3.00	OPERATION OF PLANT	7.00	0	323,807	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,848	0		4.00
5.00	DIETARY	10.00	0	10,551	0		5.00
7.00	ADULTS & PEDIATRICS	30.00	0	48,015	0		7.00
8.00	OPERATING ROOM	50.00	0	82,568	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	1,151	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	100,942	0		10.00
11.00	CT SCAN	57.00	0	19,000	0		11.00
13.00	LABORATORY	60.00	0	23,562	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,071	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	12,626	0		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,957	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,417	0		17.00
18.00	RURAL HEALTH CLINIC	88.00	0	187,105	0		18.00
19.00	EMERGENCY	91.00	0	29,343	0		19.00
21.00	RADIOISOTOPE	56.00	0	2,156	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	1,995	0		22.00
	O		0	943,605			
J - LAUNDRY RECLASS							
1.00	HOUSEKEEPING	9.00	31,356	64,147	0		1.00
	O		31,356	64,147			
K - IMPLANTABLE DEVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	3	0		1.00
2.00	EMERGENCY	91.00	0	9	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3	0		3.00
5.00	OPERATING ROOM	50.00	0	27,407	0		5.00
	O		0	27,422			
L - CLINIC A&G							
1.00	RURAL HEALTH CLINIC	88.00	0	20,095	0		1.00
	O		0	20,095			
M - MINISTRY ALLOCATION RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	748,424	0		1.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00

Provider CCN: 14-1318

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

Worksheet A-6
Date/Time Prepared:
2/27/2019 4:14 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		0	748,424		
500.00	Grand Total: Decreases		31,356	3,703,528		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

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

Worksheet A-7
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	325,000	0	0	0	0	1.00
2.00	Land Improvements	363,373	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,408,024	704,698	0	704,698	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,056,046	363,498	0	363,498	538,990	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,152,443	1,068,196	0	1,068,196	538,990	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,152,443	1,068,196	0	1,068,196	538,990	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	325,000	0				1.00
2.00	Land Improvements	363,373	0				2.00
3.00	Buildings and Fixtures	16,112,722	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	7,880,554	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24,681,649	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	24,681,649	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

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

Worksheet A-7
Part II
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	623,106	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	405,135	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,028,241	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	623,106				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	405,135				2.00
3.00	Total (sum of lines 1-2)	0	1,028,241				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

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

Worksheet A-7
Part III
Date/Time Prepared:
2/27/2019 4:14 pm

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	16,801,095	0	16,801,095	0.680712	12,665	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,880,555	0	7,880,555	0.319288	5,941	2.00
3.00	Total (sum of lines 1-2)	24,681,650	0	24,681,650	1.000000	18,606	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	12,665	1,101,410	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,941	1,057,583	0	2.00
3.00	Total (sum of lines 1-2)	0	0	18,606	2,158,993	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	144,958	12,665	0	0	1,259,033	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	94,250	5,941	0	0	1,157,774	2.00
3.00	Total (sum of lines 1-2)	239,208	18,606	0	0	2,416,807	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-2,409		ADMINISTRATIVE & GENERAL	5.00	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	-5,028		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-7,291		ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,639,240				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	631,832				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-54,154		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B			MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00 Sale of drugs to other than patients	B	-569,587		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-4,295		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-125,702		ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 RHC OTHER INCOME	B		8	RURAL HEALTH CLINIC	88.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.02	MARKETING & DEVELOPMENT OTHER	A	252	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.05	ADVERTISING EXPENSE	A	-42	ADMINISTRATIVE & GENERAL	5.00	0	34.05
35.00	LOBBYING	A	-12,096	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	OPER BENEFITS	A	-7,812	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01	SHARED BENEFITS	A	-303,911	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.01
38.01	ALCOHOLIC BEVERAGES	A	8,174	ADMINISTRATIVE & GENERAL	5.00	0	38.01
38.02	PROVIDER TAX IDPA	A	-597,817	ADMINISTRATIVE & GENERAL	5.00	0	38.02
39.00	OTHER REVENUE-DIABETES	B	-1,628	DIABETIC SERVICES	76.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,690,746				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: 14-1318 Period: From 10/01/2017 To 09/30/2018 Worksheet A-8-1 Date/Time Prepared: 2/27/2019 4:14 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES	97,770	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES	428,435	339,058	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	1,820,881	3,275,817	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CORP OFFICE CHARGES	421,963	421,963	3.01
3.02	7.00	OPERATION OF PLANT	CORP OFFICE CHARGES	63,921	63,921	3.02
4.00	66.00	PHYSICAL THERAPY	CORP OFFICE CHARGES	21,085	21,085	4.00
4.01	67.00	OCCUPATIONAL THERAPY	CORP OFFICE CHARGES	5,665	5,665	4.01
4.02	68.00	SPEECH PATHOLOGY	CORP OFFICE CHARGES	799	799	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	CORP OFFICE CHARGES	91,879	91,879	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES - INTERE	144,958	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES - INTERE	94,250	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	132,684	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	1,571,821	0	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASE SERVICES	86,871	90,909	4.08
4.09	66.00	PHYSICAL THERAPY	SFI PURCHASE SERVICES	189	324	4.09
4.10	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERV	160,665	200,584	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,143,836	4,512,004	5.00

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

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

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

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

6.00	B	OSF HEALTHCARE SYSTEM	100.00	0.00	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: 14-1318

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

Worksheet A-8-1

Date/Time Prepared:
2/27/2019 4:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	97,770	9		1.00
2.00	89,377	9		2.00
3.00	-1,454,936	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	144,958	11		4.04
4.05	94,250	11		4.05
4.06	132,684	0		4.06
4.07	1,571,821	0		4.07
4.08	-4,038	0		4.08
4.09	-135	0		4.09
4.10	-39,919	0		4.10
5.00	631,832			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00			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: 14-1318

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2019 4:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,919,442	1,371,148	548,294	0	0	1.00
2.00	60.00	LABORATORY	15,600	15,600	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	203,669	203,669	0	0	0	3.00
4.00	91.00	EMERGENCY	48,823	48,823	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,187,534	1,639,240	548,294	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,371,148		1.00
2.00	60.00	LABORATORY	0	0	0	15,600		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	203,669		3.00
4.00	91.00	EMERGENCY	0	0	0	48,823		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,639,240		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,259,033	1,259,033			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,157,774		1,157,774		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,576,730	0	0	3,576,730	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,074,146	213,584	193,803	454,618	5,936,151
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	1,058,223	142,734	129,514	121,126	1,451,597
8.00 00800	LAUNDRY & LINEN SERVICE	95,503	0	0	10,735	106,238
9.00 00900	HOUSEKEEPING	326,893	15,048	13,655	98,209	453,805
10.00 01000	DIETARY	340,726	85,227	77,333	92,928	596,214
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	218,945	33,882	30,743	75,529	359,099
17.00 01700	SOCIAL SERVICE	313,305	0	0	49,683	362,988
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,028,419	136,947	124,263	345,145	1,634,774
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	601,579	69,275	62,858	144,919	878,631
53.00 05300	ANESTHESIOLOGY	51,641	2,984	2,707	0	57,332
54.00 05400	RADIOLOGY-DIAGNOSTIC	915,923	64,818	58,815	197,957	1,237,513
56.00 05600	RADIOISOTOPE	67,461	0	0	11,133	78,594
57.00 05700	CT SCAN	17,449	0	0	0	17,449
58.00 05800	MRI	243,525	0	0	0	243,525
60.00 06000	LABORATORY	1,010,693	24,543	22,269	175,768	1,233,273
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	145,662	0	0	48,567	194,229
66.00 06600	PHYSICAL THERAPY	356,198	57,326	52,017	115,218	580,759
67.00 06700	OCCUPATIONAL THERAPY	95,968	3,630	3,294	30,851	133,743
68.00 06800	SPEECH PATHOLOGY	13,675	452	410	4,338	18,875
69.00 06900	ELECTROCARDIOLOGY	193,056	16,586	15,049	64,852	289,543
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	214,904	45,572	41,351	0	301,827
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	27,422	0	0	0	27,422
73.00 07300	DRUGS CHARGED TO PATIENTS	1,470,363	14,351	13,022	72,449	1,570,185
76.00 03950	DIABETIC SERVICES	79,917	15,875	14,405	25,264	135,461
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,580,605	202,347	183,605	1,141,081	6,107,638
91.00 09100	EMERGENCY	1,443,294	78,162	70,922	296,360	1,888,738
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	25,979,032	1,223,343	1,110,035	3,576,730	25,895,603
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,413	0	15,413
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	35,690	32,326	0	68,016
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118 through 201)	25,979,032	1,259,033	1,157,774	3,576,730	25,979,032

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2017
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,936,151					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	429,924	0	1,881,521			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,465	0	0	137,703		8.00
9.00	00900	HOUSEKEEPING	134,405	0	31,365	0	619,575	9.00
10.00	01000	DIETARY	176,582	0	177,639	0	59,487	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,355	0	70,619	0	23,649	16.00
17.00	01700	SOCIAL SERVICE	107,507	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	484,176	0	285,439	49,858	95,587	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	260,227	0	144,389	11,840	48,352	50.00
53.00	05300	ANESTHESIOLOGY	16,980	0	6,219	0	2,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,518	0	135,100	24,187	45,242	54.00
56.00	05600	RADIOISOTOPE	23,277	0	0	0	0	56.00
57.00	05700	CT SCAN	5,168	0	0	0	0	57.00
58.00	05800	MRI	72,126	0	0	0	0	58.00
60.00	06000	LABORATORY	365,262	0	51,154	348	17,130	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	57,525	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	172,005	0	119,485	10,460	40,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,611	0	7,565	0	2,533	67.00
68.00	06800	SPEECH PATHOLOGY	5,590	0	942	0	316	68.00
69.00	06900	ELECTROCARDIOLOGY	85,755	0	34,569	1,876	11,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,393	0	94,985	0	31,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,122	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	465,046	0	29,912	0	10,017	73.00
76.00	03950	DIABETIC SERVICES	40,120	0	33,088	0	11,081	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,808,909	0	421,750	0	141,235	88.00
91.00	09100	EMERGENCY	559,393	0	162,912	35,642	54,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,911,441	0	1,807,132	134,211	594,664	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,565	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,145	0	74,389	3,492	24,911	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,936,151	0	1,881,521	137,703	619,575	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,009,922					10.00
11.00	01100	CAFETERIA	789,006	789,006				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,631	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	21,532	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	220,916	185,780	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	63,468	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	11,499	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,713	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	4,735	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	107,320	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	26,379	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	30,437	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	13,528	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	43,063	0	0	0	88.00
91.00	09100	EMERGENCY	0	125,921	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,009,922	789,006	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,009,922	789,006	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

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

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	611,353			16.00
17.00	01700	SOCIAL SERVICE	0	0	492,027		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	21,516	492,027	3,470,073	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	25,515	0	1,432,422	0
53.00	05300	ANESTHESIOLOGY	0	7,339	0	101,452	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,519	0	1,963,792	0
56.00	05600	RADIOISOTOPE	0	7,638	0	114,244	0
57.00	05700	CT SCAN	0	66,434	0	89,051	0
58.00	05800	MRI	0	22,152	0	337,803	0
60.00	06000	LABORATORY	0	120,198	0	1,894,685	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	6,396	0	284,529	0
66.00	06600	PHYSICAL THERAPY	0	22,198	0	944,920	0
67.00	06700	OCCUPATIONAL THERAPY	0	6,481	0	189,933	0
68.00	06800	SPEECH PATHOLOGY	0	860	0	26,583	0
69.00	06900	ELECTROCARDIOLOGY	0	28,284	0	482,040	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,109	0	523,122	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,427	0	36,971	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,099	0	2,143,259	0
76.00	03950	DIABETIC SERVICES	0	272	0	233,550	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	60,042	0	8,582,637	0
91.00	09100	EMERGENCY	0	89,874	0	2,917,035	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	611,353	492,027	25,768,101	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	19,978	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	190,953	0
200.00		Cross Foot Adjustments				0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	611,353	492,027	25,979,032	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LI THOTRI PSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	530,334	213,584	193,803	937,721	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	142,734	129,514	272,248	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	15,048	13,655	28,703	9.00
10.00 01000	DIETARY	0	85,227	77,333	162,560	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,882	30,743	64,625	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	486	136,947	124,263	261,696	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	69,275	62,858	132,133	50.00
53.00 05300	ANESTHESIOLOGY	0	2,984	2,707	5,691	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	81,513	64,818	58,815	205,146	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	15,500	0	0	15,500	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	37,080	24,543	22,269	83,892	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	72	0	0	72	65.00
66.00 06600	PHYSICAL THERAPY	0	57,326	52,017	109,343	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,630	3,294	6,924	67.00
68.00 06800	SPEECH PATHOLOGY	0	452	410	862	68.00
69.00 06900	ELECTROCARDIOLOGY	0	16,586	15,049	31,635	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,572	41,351	86,923	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,351	13,022	27,373	73.00
76.00 03950	DIABETIC SERVICES	0	15,875	14,405	30,280	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	202,347	183,605	385,952	88.00
91.00 09100	EMERGENCY	0	78,162	70,922	149,084	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	664,985	1,223,343	1,110,035	2,998,363	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,413	15,413	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	35,690	32,326	68,016	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118 through 201)	664,985	1,259,033	1,157,774	3,081,792	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:14 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	937,721				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	67,914	0	340,162		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,970	0	0	4,970	8.00
9.00	00900	HOUSEKEEPING	21,232	0	5,671	0	55,606
10.00	01000	DIETARY	27,894	0	32,115	0	5,339
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,801	0	12,767	0	2,122
17.00	01700	SOCIAL SERVICE	16,983	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,485	0	51,605	1,799	8,579
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	41,108	0	26,104	427	4,340
53.00	05300	ANESTHESIOLOGY	2,682	0	1,124	0	187
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,898	0	24,425	873	4,060
56.00	05600	RADIOISOTOPE	3,677	0	0	0	0
57.00	05700	CT SCAN	816	0	0	0	0
58.00	05800	MRI	11,394	0	0	0	0
60.00	06000	LABORATORY	57,700	0	9,248	13	1,537
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	9,087	0	0	0	0
66.00	06600	PHYSICAL THERAPY	27,171	0	21,602	378	3,591
67.00	06700	OCCUPATIONAL THERAPY	6,257	0	1,368	0	227
68.00	06800	SPEECH PATHOLOGY	883	0	170	0	28
69.00	06900	ELECTROCARDIOLOGY	13,547	0	6,250	68	1,039
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,121	0	17,172	0	2,855
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,283	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	73,463	0	5,408	0	899
76.00	03950	DIABETIC SERVICES	6,338	0	5,982	0	994
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	285,748	0	76,249	0	12,677
91.00	09100	EMERGENCY	88,366	0	29,453	1,286	4,896
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	933,818	0	326,713	4,844	53,370
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	721	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,182	0	13,449	126	2,236
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	937,721	0	340,162	4,970	55,606

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	227,908					10.00
11.00	01100	CAFETERIA	178,054	178,054				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,651	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,859	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,854	41,925	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,323	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,595	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,405	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	1,068	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	24,219	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,953	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	6,869	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	3,053	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	9,718	0	0	0	88.00
91.00	09100	EMERGENCY	0	28,416	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,908	178,054	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	227,908	178,054	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center	Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
		15.00	16.00	17.00	24.00	25.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	107,966				16.00
17.00	01700	SOCIAL SERVICE	0	0	21,842			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,800	21,842	517,585	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,507	0	222,942	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,296	0	13,575	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,100	0	324,907	0	54.00
56.00	05600	RADIOISOTOPE	0	1,349	0	6,094	0	56.00
57.00	05700	CT SCAN	0	11,734	0	28,050	0	57.00
58.00	05800	MRI	0	3,913	0	15,307	0	58.00
60.00	06000	LABORATORY	0	21,213	0	197,822	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,130	0	16,242	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,921	0	166,006	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,145	0	15,921	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	152	0	2,095	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,996	0	64,404	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	902	0	121,973	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	252	0	1,535	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,028	0	119,171	0	73.00
76.00	03950	DIABETIC SERVICES	0	48	0	46,695	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,605	0	780,949	0	88.00
91.00	09100	EMERGENCY	0	15,875	0	317,376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	107,966	21,842	2,978,649	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,134	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	87,009	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	107,966	21,842	3,081,792	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LI THOTRI PSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	97,470				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		98,780			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,447,097		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	16,535	16,535	1,327,871	-5,936,151	20,042,881
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	11,050	11,050	353,792	0	1,451,597
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	31,356	0	106,238
9.00 00900	HOUSEKEEPING	1,165	1,165	286,855	0	453,805
10.00 01000	DIETARY	6,598	6,598	271,429	0	596,214
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	2,623	2,623	220,610	0	359,099
17.00 01700	SOCIAL SERVICE	0	0	145,118	0	362,988
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,602	10,602	1,008,117	0	1,634,774
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,363	5,363	423,286	0	878,631
53.00 05300	ANESTHESIOLOGY	231	231	0	0	57,332
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	578,203	0	1,237,513
56.00 05600	RADIOISOTOPE	0	0	32,518	0	78,594
57.00 05700	CT SCAN	0	0	0	0	17,449
58.00 05800	MRI	0	0	0	0	243,525
60.00 06000	LABORATORY	1,900	1,900	513,393	0	1,233,273
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	141,858	0	194,229
66.00 06600	PHYSICAL THERAPY	4,438	4,438	336,536	0	580,759
67.00 06700	OCCUPATIONAL THERAPY	281	281	90,111	0	133,743
68.00 06800	SPEECH PATHOLOGY	35	35	12,670	0	18,875
69.00 06900	ELECTROCARDIOLOGY	1,284	1,284	189,422	0	289,543
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	0	301,827
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,422
73.00 07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	211,612	0	1,570,185
76.00 03950	DIABETIC SERVICES	1,229	1,229	73,791	0	135,461
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	15,665	15,665	3,332,925	0	6,107,638
91.00 09100	EMERGENCY	6,051	6,051	865,624	0	1,888,738
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	94,707	94,707	10,447,097	-5,936,151	19,959,452
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,315	0	0	15,413
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,763	2,758	0	0	68,016
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,259,033	1,157,774	3,576,730		5,936,151
203.00	Unit cost multiplier (Wkst. B, Part I)	12.917133	11.720733	0.342366		0.296173
204.00	Cost to be allocated (per Wkst. B, Part II)			0		937,721
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.046786
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ. FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	69,885			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	97,843		8.00
9.00	00900	HOUSEKEEPING	0	1,165	0	68,720	9.00
10.00	01000	DIETARY	0	6,598	0	6,598	29,980
11.00	01100	CAFETERIA	0	0	0	0	23,422
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,623	0	2,623	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	10,602	35,426	10,602	6,558
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,363	8,413	5,363	0
53.00	05300	ANESTHESIOLOGY	0	231	0	231	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,018	17,186	5,018	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	0	1,900	247	1,900	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	4,438	7,432	4,438	0
67.00	06700	OCCUPATIONAL THERAPY	0	281	0	281	0
68.00	06800	SPEECH PATHOLOGY	0	35	0	35	0
69.00	06900	ELECTROCARDIOLOGY	0	1,284	1,333	1,284	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,528	0	3,528	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,111	0	1,111	0
76.00	03950	DIABETIC SERVICES	0	1,229	0	1,229	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	15,665	0	15,665	0
91.00	09100	EMERGENCY	0	6,051	25,325	6,051	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	67,122	95,362	65,957	29,980
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,763	2,481	2,763	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,881,521	137,703	619,575	1,009,922
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	26.923102	1.407387	9.015934	33.686524
204.00		Cost to be allocated (per Wkst. B, Part II)	0	340,162	4,970	55,606	227,908
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.867454	0.050796	0.809168	7.602001
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	6,999					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	0			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	458	0	0	0	0	16.00
17.00	01700	191	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,648	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	563	0	0	0	0	50.00
53.00	05300	102	0	0	0	0	53.00
54.00	05400	920	0	0	0	0	54.00
56.00	05600	42	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	952	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	234	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	270	0	0	0	0	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	0	0	0	0	0	73.00
76.00	03950	120	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	382	0	0	0	0	88.00
91.00	09100	1,117	0	0	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		6,999	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		789,006	0	0	0	0	202.00
203.00		112.731247	0.000000	0.000000	0.000000	0.000000	203.00
204.00		178,054	0	0	0	0	204.00
205.00		25.439920	0.000000	0.000000	0.000000	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,484,222	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,445,591	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,900,114	50.00
53.00	05300	ANESTHESIOLOGY	834,131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,855,722	54.00
56.00	05600	RADIOISOTOPE	868,174	56.00
57.00	05700	CT SCAN	7,550,997	57.00
58.00	05800	MRI	2,517,801	58.00
60.00	06000	LABORATORY	13,658,600	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	727,021	65.00
66.00	06600	PHYSICAL THERAPY	2,523,096	66.00
67.00	06700	OCCUPATIONAL THERAPY	736,656	67.00
68.00	06800	SPEECH PATHOLOGY	97,720	68.00
69.00	06900	ELECTROCARDIOLOGY	3,214,854	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	580,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,740,232	73.00
76.00	03950	DIABETIC SERVICES	30,894	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	6,824,530	88.00
91.00	09100	EMERGENCY	10,215,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,484,222	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	611,353	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008798	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	107,966	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001554	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,470,073		3,470,073	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,432,422		1,432,422	0	0	50.00
53.00	05300 ANESTHESIOLOGY	101,452		101,452	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,963,792		1,963,792	0	0	54.00
56.00	05600 RADIOISOTOPE	114,244		114,244	0	0	56.00
57.00	05700 CT SCAN	89,051		89,051	0	0	57.00
58.00	05800 MRI	337,803		337,803	0	0	58.00
60.00	06000 LABORATORY	1,894,685		1,894,685	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	284,529	0	284,529	0	0	65.00
66.00	06600 PHYSICAL THERAPY	944,920	0	944,920	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	189,933	0	189,933	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	26,583	0	26,583	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	482,040		482,040	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	523,122		523,122	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36,971		36,971	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,143,259		2,143,259	0	0	73.00
76.00	03950 DIABETIC SERVICES	233,550		233,550	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	8,582,637		8,582,637	0	0	88.00
91.00	09100 EMERGENCY	2,917,035		2,917,035	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	444,540		444,540	0	0	92.00
200.00	Subtotal (see instructions)	26,212,641	0	26,212,641	0	0	200.00
201.00	Less Observation Beds	444,540		444,540	0	0	201.00
202.00	Total (see instructions)	25,768,101	0	25,768,101	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,608,796		2,608,796		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,924	2,810,190	2,900,114	0.493919	50.00
53.00	05300	ANESTHESIOLOGY	35,257	798,874	834,131	0.121626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,194	5,752,528	5,855,722	0.335363	54.00
56.00	05600	RADIOISOTOPE	4,934	863,240	868,174	0.131591	56.00
57.00	05700	CT SCAN	184,391	7,366,606	7,550,997	0.011793	57.00
58.00	05800	MRI	48,861	2,468,940	2,517,801	0.134166	58.00
60.00	06000	LABORATORY	854,551	12,804,049	13,658,600	0.138717	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	591,608	135,413	727,021	0.391363	65.00
66.00	06600	PHYSICAL THERAPY	334,614	2,188,482	2,523,096	0.374508	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,171	597,485	736,656	0.257831	67.00
68.00	06800	SPEECH PATHOLOGY	39,675	58,045	97,720	0.272032	68.00
69.00	06900	ELECTROCARDIOLOGY	108,722	3,106,132	3,214,854	0.149941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	269,198	311,461	580,659	0.900911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,192	129,985	162,177	0.227967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,756	6,269,476	7,740,232	0.276899	73.00
76.00	03950	DIABETIC SERVICES	0	30,894	30,894	7.559720	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,824,530	6,824,530		88.00
91.00	09100	EMERGENCY	124,781	9,497,930	9,622,711	0.303141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,773	410,564	429,337	1.035410	92.00
200.00		Subtotal (see instructions)	7,059,398	62,424,824	69,484,222		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,059,398	62,424,824	69,484,222		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 4:14 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 DIABETIC SERVICES	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

		Title XIX		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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,470,073		3,470,073	0	3,470,073 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,432,422		1,432,422	0	1,432,422 50.00
53.00	05300 ANESTHESIOLOGY	101,452		101,452	0	101,452 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,963,792		1,963,792	0	1,963,792 54.00
56.00	05600 RADIOISOTOPE	114,244		114,244	0	114,244 56.00
57.00	05700 CT SCAN	89,051		89,051	0	89,051 57.00
58.00	05800 MRI	337,803		337,803	0	337,803 58.00
60.00	06000 LABORATORY	1,894,685		1,894,685	0	1,894,685 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	284,529	0	284,529	0	284,529 65.00
66.00	06600 PHYSICAL THERAPY	944,920	0	944,920	0	944,920 66.00
67.00	06700 OCCUPATIONAL THERAPY	189,933	0	189,933	0	189,933 67.00
68.00	06800 SPEECH PATHOLOGY	26,583	0	26,583	0	26,583 68.00
69.00	06900 ELECTROCARDIOLOGY	482,040		482,040	0	482,040 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	523,122		523,122	0	523,122 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	36,971		36,971	0	36,971 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,143,259		2,143,259	0	2,143,259 73.00
76.00	03950 DIABETIC SERVICES	233,550		233,550	0	233,550 76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	8,582,637		8,582,637	0	8,582,637 88.00
91.00	09100 EMERGENCY	2,917,035		2,917,035	0	2,917,035 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	444,540		444,540	0	444,540 92.00
200.00	Subtotal (see instructions)	26,212,641	0	26,212,641	0	26,212,641 200.00
201.00	Less Observation Beds	444,540		444,540	0	444,540 201.00
202.00	Total (see instructions)	25,768,101	0	25,768,101	0	25,768,101 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,608,796		2,608,796			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,924	2,810,190	2,900,114	0.493919	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	35,257	798,874	834,131	0.121626	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,194	5,752,528	5,855,722	0.335363	0.000000	54.00
56.00	05600	RADIOISOTOPE	4,934	863,240	868,174	0.131591	0.000000	56.00
57.00	05700	CT SCAN	184,391	7,366,606	7,550,997	0.011793	0.000000	57.00
58.00	05800	MRI	48,861	2,468,940	2,517,801	0.134166	0.000000	58.00
60.00	06000	LABORATORY	854,551	12,804,049	13,658,600	0.138717	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	591,608	135,413	727,021	0.391363	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	334,614	2,188,482	2,523,096	0.374508	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,171	597,485	736,656	0.257831	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	39,675	58,045	97,720	0.272032	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	108,722	3,106,132	3,214,854	0.149941	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	269,198	311,461	580,659	0.900911	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,192	129,985	162,177	0.227967	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,756	6,269,476	7,740,232	0.276899	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	30,894	30,894	7.559720	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	6,824,530	6,824,530	1.257616	0.000000	88.00
91.00	09100	EMERGENCY	124,781	9,497,930	9,622,711	0.303141	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,773	410,564	429,337	1.035410	0.000000	92.00
200.00		Subtotal (see instructions)	7,059,398	62,424,824	69,484,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,059,398	62,424,824	69,484,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 4:14 pm
	Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.493919	50.00
53.00	05300 ANESTHESIOLOGY	0.121626	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.335363	54.00
56.00	05600 RADIOISOTOPE	0.131591	56.00
57.00	05700 CT SCAN	0.011793	57.00
58.00	05800 MRI	0.134166	58.00
60.00	06000 LABORATORY	0.138717	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.391363	65.00
66.00	06600 PHYSICAL THERAPY	0.374508	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257831	67.00
68.00	06800 SPEECH PATHOLOGY	0.272032	68.00
69.00	06900 ELECTROCARDIOLOGY	0.149941	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.900911	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.227967	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276899	73.00
76.00	03950 DIABETIC SERVICES	7.559720	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699 LI THOTRI PSY	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	1.257616	88.00
91.00	09100 EMERGENCY	0.303141	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.035410	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1318

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

Worksheet C
Part II
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,432,422	222,942	1,209,480	0	0	50.00
53.00	05300	ANESTHESIOLOGY	101,452	13,575	87,877	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,963,792	324,907	1,638,885	0	0	54.00
56.00	05600	RADIOISOTOPE	114,244	6,094	108,150	0	0	56.00
57.00	05700	CT SCAN	89,051	28,050	61,001	0	0	57.00
58.00	05800	MRI	337,803	15,307	322,496	0	0	58.00
60.00	06000	LABORATORY	1,894,685	197,822	1,696,863	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	284,529	16,242	268,287	0	0	65.00
66.00	06600	PHYSICAL THERAPY	944,920	166,006	778,914	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,933	15,921	174,012	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,583	2,095	24,488	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	482,040	64,404	417,636	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	523,122	121,973	401,149	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,971	1,535	35,436	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,143,259	119,171	2,024,088	0	0	73.00
76.00	03950	DIABETIC SERVICES	233,550	46,695	186,855	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,582,637	780,949	7,801,688	0	0	88.00
91.00	09100	EMERGENCY	2,917,035	317,376	2,599,659	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	444,540	66,306	378,234	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	22,742,568	2,527,370	20,215,198	0	0	200.00
201.00		Less Observation Beds	444,540	66,306	378,234	0	0	201.00
202.00		Total (line 200 minus line 201)	22,298,028	2,461,064	19,836,964	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1318

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

Worksheet C
Part II
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX						
		Hospital		PPS		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,432,422	2,900,114	0.493919	50.00
53.00	05300	ANESTHESIOLOGY	101,452	834,131	0.121626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,963,792	5,855,722	0.335363	54.00
56.00	05600	RADIOISOTOPE	114,244	868,174	0.131591	56.00
57.00	05700	CT SCAN	89,051	7,550,997	0.011793	57.00
58.00	05800	MRI	337,803	2,517,801	0.134166	58.00
60.00	06000	LABORATORY	1,894,685	13,658,600	0.138717	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	284,529	727,021	0.391363	65.00
66.00	06600	PHYSICAL THERAPY	944,920	2,523,096	0.374508	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,933	736,656	0.257831	67.00
68.00	06800	SPEECH PATHOLOGY	26,583	97,720	0.272032	68.00
69.00	06900	ELECTROCARDIOLOGY	482,040	3,214,854	0.149941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	523,122	580,659	0.900911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,971	162,177	0.227967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,143,259	7,740,232	0.276899	73.00
76.00	03950	DIABETIC SERVICES	233,550	30,894	7.559720	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,582,637	6,824,530	1.257616	88.00
91.00	09100	EMERGENCY	2,917,035	9,622,711	0.303141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	444,540	429,337	1.035410	92.00
200.00		Subtotal (sum of lines 50 thru 199)	22,742,568	66,875,426		200.00
201.00		Less Observation Beds	444,540	0		201.00
202.00		Total (line 200 minus line 201)	22,298,028	66,875,426		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	222,942	2,900,114	0.076874	22,113	1,700	50.00
53.00	05300 ANESTHESIOLOGY	13,575	834,131	0.016274	8,252	134	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	324,907	5,855,722	0.055485	30,615	1,699	54.00
56.00	05600 RADIOISOTOPE	6,094	868,174	0.007019	0	0	56.00
57.00	05700 CT SCAN	28,050	7,550,997	0.003715	51,201	190	57.00
58.00	05800 MRI	15,307	2,517,801	0.006080	10,687	65	58.00
60.00	06000 LABORATORY	197,822	13,658,600	0.014483	272,085	3,941	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	16,242	727,021	0.022340	193,728	4,328	65.00
66.00	06600 PHYSICAL THERAPY	166,006	2,523,096	0.065795	44,028	2,897	66.00
67.00	06700 OCCUPATIONAL THERAPY	15,921	736,656	0.021613	9,752	211	67.00
68.00	06800 SPEECH PATHOLOGY	2,095	97,720	0.021439	14,043	301	68.00
69.00	06900 ELECTROCARDIOLOGY	64,404	3,214,854	0.020033	61,401	1,230	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	121,973	580,659	0.210060	120,754	25,366	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,535	162,177	0.009465	32,192	305	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	119,171	7,740,232	0.015396	424,500	6,536	73.00
76.00	03950 DIABETIC SERVICES	46,695	30,894	1.511459	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	780,949	6,824,530	0.114433	0	0	88.00
91.00	09100 EMERGENCY	317,376	9,622,711	0.032982	4,045	133	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	66,306	429,337	0.154438	5,293	817	92.00
200.00	Total (lines 50 through 199)	2,527,370	66,875,426		1,304,689	49,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description	Title XVIII					Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description		Title XVIII			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,900,114	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	834,131	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,855,722	0.000000	54.00
56.00	05600	RADIO SOTOPE	0	0	0	868,174	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	7,550,997	0.000000	57.00
58.00	05800	MRI	0	0	0	2,517,801	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	13,658,600	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	727,021	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,523,096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	736,656	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	97,720	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,214,854	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	580,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	162,177	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,740,232	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	30,894	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,824,530	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,622,711	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	429,337	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	66,875,426		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	22,113	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	8,252	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	30,615	0	0	0 54.00
56.00	05600	RADIO SOTOPE	0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	51,201	0	0	0 57.00
58.00	05800	MRI	0.000000	10,687	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	272,085	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	193,728	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	44,028	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,752	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,043	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	61,401	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	120,754	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	32,192	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	424,500	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	4,045	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,293	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,304,689	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.493919	0	624,748	0	50.00
53.00	05300 ANESTHESIOLOGY	0.121626	0	172,759	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.335363	0	1,705,024	0	54.00
56.00	05600 RADIOISOTOPE	0.131591	0	271,591	0	56.00
57.00	05700 CT SCAN	0.011793	0	2,484,089	0	57.00
58.00	05800 MRI	0.134166	0	733,848	0	58.00
60.00	06000 LABORATORY	0.138717	0	4,223,337	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.391363	0	73,719	0	65.00
66.00	06600 PHYSICAL THERAPY	0.374508	0	837,231	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257831	0	145,064	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.272032	0	22,263	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.149941	0	1,138,131	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.900911	0	95,040	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.227967	0	16,399	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276899	0	3,125,799	4,889	73.00
76.00	03950 DIABETIC SERVICES	7.559720	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699 LI THOTRIpsy	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100 EMERGENCY	0.303141	0	2,791,970	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.035410	0	211,415	0	92.00
200.00	Subtotal (see instructions)		0	18,672,427	4,889	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	18,672,427	4,889	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	308,575	0	50.00
53.00	05300 ANESTHESIOLOGY	21,012	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	571,802	0	54.00
56.00	05600 RADIOISOTOPE	35,739	0	56.00
57.00	05700 CT SCAN	29,295	0	57.00
58.00	05800 MRI	98,457	0	58.00
60.00	06000 LABORATORY	585,849	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	28,851	0	65.00
66.00	06600 PHYSICAL THERAPY	313,550	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	37,402	0	67.00
68.00	06800 SPEECH PATHOLOGY	6,056	0	68.00
69.00	06900 ELECTROCARDIOLOGY	170,653	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	85,623	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,738	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	865,531	1,354	73.00
76.00	03950 DIABETIC SERVICES	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	846,361	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	218,901	0	92.00
200.00	Subtotal (see instructions)	4,227,395	1,354	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	4,227,395	1,354	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1318

Period: From 10/01/2017

Worksheet D

Component CCN: 14-Z318

To 09/30/2018

Part V
Date/Time Prepared:
2/27/2019 4:14 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs				
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)				
						1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.493919	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121626	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.335363	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.131591	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.011793	0	0	0	0	0	57.00
58.00	05800	MRI	0.134166	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.138717	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.391363	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.374508	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257831	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.272032	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.149941	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.900911	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227967	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276899	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	7.559720	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000						88.00
91.00	09100	EMERGENCY	0.303141	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.035410	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:14 pm
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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 PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part I Date/Time Prepared: 2/27/2019 4:14 pm		
Cost Center Description		Title XIX		Hospital		PPS		
		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		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	517,585	254,669	262,916	797	329.88	30.00	
200.00	Total (lines 30 through 199)	517,585		262,916	797		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	90	29,689					30.00
200.00	Total (lines 30 through 199)	90	29,689					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	222,942	2,900,114	0.076874	0	0	50.00
53.00	05300 ANESTHESIOLOGY	13,575	834,131	0.016274	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	324,907	5,855,722	0.055485	0	0	54.00
56.00	05600 RADIOISOTOPE	6,094	868,174	0.007019	0	0	56.00
57.00	05700 CT SCAN	28,050	7,550,997	0.003715	0	0	57.00
58.00	05800 MRI	15,307	2,517,801	0.006080	0	0	58.00
60.00	06000 LABORATORY	197,822	13,658,600	0.014483	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	16,242	727,021	0.022340	0	0	65.00
66.00	06600 PHYSICAL THERAPY	166,006	2,523,096	0.065795	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	15,921	736,656	0.021613	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,095	97,720	0.021439	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	64,404	3,214,854	0.020033	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	121,973	580,659	0.210060	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,535	162,177	0.009465	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	119,171	7,740,232	0.015396	0	0	73.00
76.00	03950 DIABETIC SERVICES	46,695	30,894	1.511459	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	780,949	6,824,530	0.114433	0	0	88.00
91.00	09100 EMERGENCY	317,376	9,622,711	0.032982	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	66,306	429,337	0.154438	0	0	92.00
200.00	Total (lines 50 through 199)	2,527,370	66,875,426		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part III Date/Time Prepared: 2/27/2019 4:14 pm		
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	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	797	0.00	90	30.00	
200.00		Total (lines 30 through 199)	0	0	797		90	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:14 pm
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Cost Center Description	Title XIX				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		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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 PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,900,114	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	834,131	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,855,722	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	868,174	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	7,550,997	0.000000	57.00
58.00	05800	MRI	0	0	0	2,517,801	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	13,658,600	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	727,021	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,523,096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	736,656	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	97,720	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,214,854	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	580,659	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	162,177	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,740,232	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	30,894	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,824,530	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,622,711	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	429,337	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	66,875,426		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Title XIX			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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	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	0	0	0	0	73.00
76.00	03950 DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:14 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		797	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)		596	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		165	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)		607	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		19	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)		73	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		374	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)		44	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)		537	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		3,470,073	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)		1,707,394	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,762,679	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,762,679	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,211.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		827,157	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)		827,157	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Cost Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					410,200	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,237,357	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					97,313	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,187,656	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,284,969	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)					201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,211.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					444,540	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:14 pm	
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	517,585	3,470,073	0.149157	444,540	66,306	90.00
91.00	Nursing School cost	0	3,470,073	0.000000	444,540	0	91.00
92.00	Allied health cost	0	3,470,073	0.000000	444,540	0	92.00
93.00	All other Medical Education	0	3,470,073	0.000000	444,540	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/27/2019 4:14 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		797	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)		596	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)		772	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		24	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)		68	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		90	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
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		3,470,073	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)		1,707,394	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,762,679	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,762,679	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,211.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		199,048	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)		199,048	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					199,048	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)					29,689	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					29,689	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					169,359	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)					201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,211.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					444,540	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:14 pm	
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	517,585	3,470,073	0.149157	444,540	66,306	90.00
91.00	Nursing School cost	0	3,470,073	0.000000	444,540	0	91.00
92.00	Allied health cost	0	3,470,073	0.000000	444,540	0	92.00
93.00	All other Medical Education	0	3,470,073	0.000000	444,540	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		613,469		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.493919	22,113	10,922	50.00
53.00	05300 ANESTHESIOLOGY	0.121626	8,252	1,004	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.335363	30,615	10,267	54.00
56.00	05600 RADIOISOTOPE	0.131591	0	0	56.00
57.00	05700 CT SCAN	0.011793	51,201	604	57.00
58.00	05800 MRI	0.134166	10,687	1,434	58.00
60.00	06000 LABORATORY	0.138717	272,085	37,743	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.391363	193,728	75,818	65.00
66.00	06600 PHYSICAL THERAPY	0.374508	44,028	16,489	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257831	9,752	2,514	67.00
68.00	06800 SPEECH PATHOLOGY	0.272032	14,043	3,820	68.00
69.00	06900 ELECTROCARDIOLOGY	0.149941	61,401	9,207	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.900911	120,754	108,789	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.227967	32,192	7,339	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276899	424,500	117,544	73.00
76.00	03950 DIABETIC SERVICES	7.559720	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.303141	4,045	1,226	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.035410	5,293	5,480	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,304,689	410,200	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)		1,304,689		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.493919	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.121626	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.335363	15,391	5,162	54.00
56.00	05600 RADIOISOTOPE	0.131591	0	0	56.00
57.00	05700 CT SCAN	0.011793	15,826	187	57.00
58.00	05800 MRI	0.134166	0	0	58.00
60.00	06000 LABORATORY	0.138717	174,366	24,188	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.391363	218,486	85,507	65.00
66.00	06600 PHYSICAL THERAPY	0.374508	201,442	75,442	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257831	87,692	22,610	67.00
68.00	06800 SPEECH PATHOLOGY	0.272032	9,712	2,642	68.00
69.00	06900 ELECTROCARDIOLOGY	0.149941	2,274	341	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.900911	71,847	64,728	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.227967	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276899	315,005	87,225	73.00
76.00	03950 DIABETIC SERVICES	7.559720	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.303141	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.035410	510	528	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,112,551	368,560	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)		1,112,551		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,228,749 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,228,749 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,271,036 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			36,541 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,902,407 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)			1,332,088 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)			1,332,088 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			1,332,088 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			294,835 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			191,643 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			1,523,731 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)			1,523,731 40.00
40.01	Sequestration adjustment (see instructions)			30,475 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			1,702,396 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-209,140 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1318		Period: From 10/01/2017 To 09/30/2018		Worksheet E-1 Part I Date/Time Prepared: 2/27/2019 4:14 pm	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		850,832		1,354,024	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	04/26/2018	71,847	04/26/2018	86,027	3.01	
3.02		09/25/2018	30,388	09/25/2018	262,345	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)		102,235		348,372	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)		953,067		1,702,396	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		150,214		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		209,140	6.02	
7.00	Total Medicare program liability (see instructions)		1,103,281		1,493,256	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: 14-1318
Component CCN: 14-Z318

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2019 4:14 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,284,373		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	04/26/2018	85,241		0	3.01
3.02		09/25/2018	97,024		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)		182,265		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,466,638		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		151,424		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,618,062		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: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2017 To 09/30/2018	Worksheet E-2 Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,297,819	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)	372,246	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	581	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)	1,670,065	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,670,065	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)	1,670,065	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,981	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)	1,651,084	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)	1,651,084	0	19.00
19.01	Sequestration adjustment (see instructions)	33,022	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	1,466,638	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)	151,424	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/27/2019 4:14 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,237,357 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,237,357 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,249,731 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,249,731 19.00
20.00	Deductibles (exclude professional component)			149,504 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,100,227 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,100,227 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			39,339 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			25,570 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,125,797 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			1,125,797 30.00
30.01	Sequestration adjustment (see instructions)			22,516 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			953,067 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			150,214 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 14-1318

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

Worksheet G

Date/Time Prepared:
2/27/2019 4:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	349,786	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	13,622,899	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,873,327	0	0	0	6.00
7.00	Inventory	449,974	0	0	0	7.00
8.00	Prepaid expenses	71,169	0	0	0	8.00
9.00	Other current assets	435,102	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,055,603	0	0	0	11.00
FIXED ASSETS						
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	363,373	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,112,722	0	0	0	15.00
16.00	Accumulated depreciation	-4,581,796	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-237,864	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,880,555	0	0	0	23.00
24.00	Accumulated depreciation	-4,151,149	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	2,915,370	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,626,211	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	14,569,317	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	6,631,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,201,115	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,882,929	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	680,501	0	0	0	37.00
38.00	Salaries, wages, and fees payable	932,448	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,263	0	0	0	43.00
44.00	Other current liabilities	289,801	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,905,013	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	238,614	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	238,614	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,143,627	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,739,302				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,739,302	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,882,929	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1318

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

Worksheet G-1

Date/Time Prepared:
2/27/2019 4:14 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		40,245,155		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,176,549			2.00
3.00	Total (sum of line 1 and line 2)		45,421,704		0	3.00
4.00	CONTRIBUTIONS	31,737		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		31,737		0	10.00
11.00	Subtotal (line 3 plus line 10)		45,453,441		0	11.00
12.00	ASSETS RELEASED	601,843		0		12.00
13.00	EQUITY TRANSFER ACCT 231095	-11,675		0		13.00
14.00	EQUITY TRANSFER ACCT 86100-719850	123,971		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		714,139		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,739,302		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	CONTRIBUTIONS		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	ASSETS RELEASED		0			12.00
13.00	EQUITY TRANSFER ACCT 231095		0			13.00
14.00	EQUITY TRANSFER ACCT 86100-719850		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: 14-1318

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2019 4:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,016,254		2,016,254	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,016,254		2,016,254	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,016,254		2,016,254	17.00
18.00	Ancillary services	4,307,048	45,686,539	49,993,587	18.00
19.00	Outpatient services	144,321	10,500,269	10,644,590	19.00
20.00	RURAL HEALTH CLINIC	0	6,824,530	6,824,530	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	55,173	4,073,806	4,128,979	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,522,796	67,085,144	73,607,940	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,669,778		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)		28,669,778		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1318

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

Worksheet G-3

Date/Time Prepared:
2/27/2019 4:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,607,940	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,444,114	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,163,826	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,669,778	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,494,048	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	672,914	6.00
7.00	Income from investments	610,463	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	75,000	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	54,154	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	4,620	16.00
17.00	Revenue from sale of drugs to other than patients	1,011,696	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,125	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER GRANT INCOME	252,529	24.00
25.00	Total other income (sum of lines 6-24)	2,682,501	25.00
26.00	Total (line 5 plus line 25)	5,176,549	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,176,549	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2017 To 09/30/2018		Worksheet M-1 Date/Time Prepared: 2/27/2019 4:14 pm	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,032,085	220,446	1,252,531	-220,446	1,032,085	1.00
2.00	Physician Assistant	350,105	74,780	424,885	-74,780	350,105	2.00
3.00	Nurse Practitioner	295,952	63,213	359,165	-63,213	295,952	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	700,431	149,607	850,038	-149,607	700,431	5.00
6.00	Clinical Psychologist	114,870	24,535	139,405	-24,535	114,870	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	185,733	39,671	225,404	-39,671	185,733	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,679,176	572,252	3,251,428	-572,252	2,679,176	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	36,275	36,275	-28,387	7,888	15.00
16.00	Transportation (Health Care Staff)	0	15,944	15,944	0	15,944	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	39,008	39,008	0	39,008	18.00
19.00	Other Health Care Costs	0	1,167,664	1,167,664	0	1,167,664	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,258,891	1,258,891	-28,387	1,230,504	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,679,176	1,831,143	4,510,319	-600,639	3,909,680	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	175,547	175,547	-175,547	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	175,547	175,547	-175,547	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	653,750	364,004	1,017,754	-346,837	670,917	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	653,750	364,004	1,017,754	-346,837	670,917	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,332,926	2,370,694	5,703,620	-1,123,023	4,580,597	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period: From 10/01/2017

Worksheet M-1

Component CCN: 14-3461

To 09/30/2018

Date/Time Prepared: 2/27/2019 4:14 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,032,085		1.00
2.00	Physician Assistant	0	350,105		2.00
3.00	Nurse Practitioner	0	295,952		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	700,431		5.00
6.00	Clinical Psychologist	0	114,870		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	185,733		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,679,176		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	7,888		15.00
16.00	Transportation (Health Care Staff)	0	15,944		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	39,008		18.00
19.00	Other Health Care Costs	0	1,167,664		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,230,504		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,909,680		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	8	8		29.00
30.00	Administrative Costs	0	670,917		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	8	670,925		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	8	4,580,605		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2017 To 09/30/2018	Worksheet M-2 Date/Time Prepared: 2/27/2019 4:14 pm
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		RHC 1		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	4.04	12,562	4,200	16,968	1.00
2.00	Physician Assistant	2.19	13,339	2,100	4,599	2.00
3.00	Nurse Practitioner	2.60	3,951	2,100	5,460	3.00
4.00	Subtotal (sum of lines 1 through 3)	8.83	29,852		27,027	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	1.80	1,857		1,857	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)	10.63	31,709		31,709	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				3,909,680	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,909,680	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				670,925	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				4,002,032	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,672,957	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,672,957	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,672,957	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				8,582,637	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 4:14 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,582,637	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			198,268	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,384,369	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			31,709	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)			31,709	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			264.42	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)	264.42	264.42		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,600	4,802	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	423,072		1,269,745	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		1,692,817	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,356,212	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,117	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,642	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.)			1,263,714	16.04
16.05	Total program cost (see instructions)		0	1,266,356	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			110,532	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			248,713	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,266,356	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			63,043	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,329,399	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,329,399	26.00
26.01	Sequestration adjustment (see instructions)			26,588	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,235,397	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)			67,414	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: 14-1318 Component CCN: 14-3461	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 4:14 pm
Title XVIII		RHC I	Cost	
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,679,176	2,679,176	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001942	0.007692	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,203	20,608	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	37,304	27,203	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	42,507	47,811	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,909,680	3,909,680	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,672,957	4,672,957	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010872	0.012229	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	50,804	57,146	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	93,311	104,957	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	445	1,763	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	209.69	59.53	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	157	506	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	32,921	30,122	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)		198,268	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)		63,043	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 4:14 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,158,477	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		04/26/2018	45,267	3.01
3.02		09/25/2018	31,653	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)		76,920	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,235,397	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		67,414	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,302,811	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00